7200 Jim Cottrell Circle, Palmer, AK 99645 Phone: (907) 982-3897 Fax: (866) 283-2986

Patient Registration

Client Name: _____Date of Birth: _____ Male/Female (please circle)

Parent/Guardian Name(s): _____

Mailing Address: _____

City, State, Zip: _____

Phone: Primary: _____Secondary: _____Additional: _____

Email:

Referring Physician: _____

Other Physician(s): _____

Insurance Provider: _____ID Number: _____

Primary Insured: _____Group Number: _____

Primary Insured Date of Birth_____

Secondary Insurance: _____ID Number: _____

Primary Insured: _____Group Number: _____

Primary Insured Date of Birth_____

Allergies: _____

Injuries or Surgeries: _____

Current Medications: _____

Prior or Current PT/OT/SLP Services (circle one): YES NO

Emergency Contact: _____Phone: _____

Relationship to client: _____

I certify that the information above is true to the best of my knowledge. I have read and understand the Privacy Policy provided by Backcountry Therapeutics, LLC _____ (please initial)

_____

Client/Parent/Guardian Date

BACKCOUNTRY THERAPEUTICS
7200 Jim Cottrell Circle, Palmer, AK 99645 Phone: (907) 982-3897 Fax: (866) 283-2986

Authorization to Release or Obtain Information

Regarding: _____ Date of Birth: _____

I authorize Backcountry Therapeutics, LLC to (check all that apply):

_____ Receive and use the following protected information, and/or
_____ Disclose the following protected information to:
_____
_____ (Name of person/organization to exchange information)

Specific description/type of information with a date range: _____
(ex. Evaluation, report, IEP, progress report/notes, eligibility information, financial, and dates)

This protected information is being used or disclosed for the following purposes:
This authorization will expire on _____/_____/_____ (MM/DD/YY)

I understand this authorization is voluntary and may be revoked at any time by signing the revocation section on this form, or by notifying the individual(s) or organization releasing this information in writing; the revocation will not have any effect on any prior actions taken. I understand that I may receive a copy of this authorization and view and/or copy the information described on this authorization.

_____ _____
Signature Date

NOTE: This authorization was revoked on: _____

BACKCOUNTRY THERAPEUTICS
7200 Jim Cottrell Circle, Palmer, AK 99645 Phone: (907) 982-3897 Fax: (866) 283-2986

Consent for Treatment, Consent to Photograph/Use Photographs on Website, Billing and Communication

Client's Name _____Date of Birth_____

Consent to evaluate and treat:

I hereby authorize the occupational, physical and speech therapists of Backcountry Therapeutics, LLC to evaluate myself or my dependent for the appropriateness of rehabilitation services. I understand that the findings will be used only in the best interest of myself or my dependent. I understand that the findings will be discussed in full with me. I understand that the complete Plan of Care will be discussed with me in full and treatment is designed in the best interest of myself or my dependent. _____ **(please initial)**

Consent to Photograph:

I hereby give permission to the therapists of Backcountry Therapeutics, LLC, to use photography or videotaping for the following purpose:

- Documentation of current status for baseline or comparison to earlier date
- For communication with other medical practitioners
- For educational purposes.

Any questions or concerns regarding the use of photography or videotape have been addressed by my primary therapist.

Consent to Photograph_____ (please initial) DO NOT Consent to Photograph_____ (please initial)

Consent to Use Photographs on Website:

I hereby give permission to the therapists of Backcountry Therapeutics, LLC to take photographs and use videotaping for display on the Backcountry Therapeutics, LLC website for the purpose of introducing new clients to this practice and to the benefits of Occupational Therapy, Speech Therapy, and Physical Therapy.
Any questions or concerns regarding the use of photographs or videotapes have been addressed by my primary therapist.

Consent to Use Photographs on Website_____ (please initial)

Do not Consent to Use Photographs on Website_____ (please initial)

Email Communication:

I give Backcountry Therapeutics, LLC permission to correspond with my child's legal guardians and care team via e-mail regarding treatment and documentation. I understand that text messages and emails associated with Backcountry Therapeutics, LLC are business accounts that are HIPPA compliant. Backcountry Therapeutics, LLC cannot fully ensure the confidentiality of any form of communication through electronic media including text messages and email. I understand that while Backcountry Therapeutics, LLC email is HIPPA compliant, my email or cell phone may not be HIPAA compliant, and correspondence may potentially be intercepted by an outside party.

Consent to Use Email Communication _____ (Please Initial)
DO NOT Consent to use Email Communication _____ (Please Initial)

Text Communication:

I authorize Backcountry Therapeutics, LLC to send text messages related to my child's therapy on my cell phone. I understand that communication via text message is not secure and may potentially be intercepted by a third party. I understand that standard data and text messaging rates will apply to any messages received from Backcountry Therapeutics, LLC. I agree not to hold Backcountry Therapeutics, LLC liable for any electronic messaging charges or fees generated by this service.

Consent to Use Text Communication _____ (Please Initial)
DO NOT Consent to use Text Communication _____ (Please Initial)

Billing Policy:

I authorize payment of medical benefits to Andrea Rapson, dba Backcountry Therapeutics, LLC. I understand that payment of therapy charges is ultimately my responsibility. I agree to pay my portion of the insurance deductible, co-insurance or co-payment within thirty (30) days of receiving the bill. _____ **(please initial)**
By signing and initialing, I authorize and **Consent to Evaluate and Treat, Consent to Photograph, Consent to Use Photographs on Website,** and understand and agree to the **Billing and No-Show Policy.**

_____

Parent or Legal Guardian Signature Date

7200 Jim Cottrell Circle, Palmer, AK 99645 Phone: (907) 982-3897 Fax: (866) 283-2986

COMMITMENT AND ATTENDANCE POLICY

We at Backcountry Therapeutics, LLC love working with the kids we see. We celebrate their successes, puzzle over and research how to best help them, take classes to improve our skills, and take time and effort to prepare for their appointments. It is our highest commitment to help them to the best of our ability, and more importantly to help you help your child.

This is not possible without the teamwork of the parents, family and caregivers who spend way more time with our clients. Because of this, we ask for your commitment with the following actions:

• When requested, observe and participate with appointments, asking questions as they arise. This becomes less necessary with time, but initially is very important, particularly to implement home recommendations.

• Attempt to implement therapeutic recommendations into your home life and report back. Keep in mind that some interventions take repetition, consistency and time before results are observable.

• If you are not happy or comfortable with our treatment or suggestions, please tell us. We honor and appreciate your feedback and will do our best to meet your needs as a parent.

• Attend your regularly scheduled appointment to the best of your ability, and reschedule if you are unable to attend during your usual day and time slot. Please notify us as soon as you know you are not able to attend your appointment.

Attendance Policy
If you are unable to come to appointments on a consistent basis, we will place your child on a temporary waiting list and make your time slot available to others until you are able to attend regularly again. Inconsistent attendance will be defined as the following:
• An attendance rate of less than 75% over the course of three months
• Vacations, sickness or hospitalizations that exceed 4 weeks
• After two no call/no shows your child will be placed on the Waiting List and on the Cancellation Call List until you are able to attend regularly. No call/no show is defined as ***a missed appointment with no prior notification.***
• More than 15 minutes late, without notification, will be considered a partial no call/no show. Multiple tardies will be subject to a late fee.

Constant tardiness adversely affects your child's ability to benefit from therapy.

If you anticipate any of these inconsistencies in your schedule, please inform us ahead of time so we can make reasonable arrangements, choose to enroll your child when you are available for regular appointments, or opt for calling first thing in the morning and scheduling your child in an available slot. ***Please let us know if you are not getting reminder texts.***
A $50.00 fee will be charged for any appointments cancelled less than 12 hours prior to the appointment time as well as any no call/no show appointment. In addition, all no call/no show appointments will be reported to Medicaid whether Medicaid is the Primary or the Secondary insurance.

_____
Parent/Guardian Signature

7200 Jim Cottrell Circle, Palmer, AK 99645 Phone: (907) 982-3897 Fax: (866) 283-2986

EQUINE–ASSISTED THERAPY RELEASE, WAIVER OF LIABILITY, AND INDEMNIFICATION AGREEMENT

I, _____, on behalf of myself and/or my minor child, _____,
(Name) (Child's Name)
make the following voluntary agreements with Backcountry Therapeutics, LLC:

ASSUMPTION OF RISKS. I specifically acknowledge that the inherent risks associated with Equine Assisted Therapy include but are not limited to: falling or being thrown from a horse, impacting the ground or other objects, being kicked, bitten, or knocked over by a horse, laid on by a horse, colliding with other horses and/or participants, being stepped on, being rolled on by a horse, allergic reactions, bruised or broken bones, head injuries, paralysis and even death. These risks are inherent in the participation of Equine Assisted Therapy and therefore cannot be eliminated. I understand these risks and expressly agree and promise to accept and assume all the risks of participating in Equine Assisted Therapy.

VOLUNTARY PARTICIPATION. I am voluntarily participating in Equine-Assisted Therapy at my OWN RISK. I understand that serious accidents can and do occur. I understand that Backcountry Therapeutics, LLC and its employees, instructors, therapists, volunteers, contractors, subcontractors, and agents seek the safety of all participants but WE ARE NOT INFALLIBLE. Equipment, tack or gear may fail and cause serious injury or death. We may misjudge the nature, character, skills and abilities of a horse or participant. We may fail to give adequate warnings or instructions, and we cannot always be in close enough proximity to prevent or minimize every injury or accident. I understand and acknowledge that I am ultimately responsible for my own safety while participating in Equine Assisted Therapy. I agree that my participation is voluntary and I VOLUNTARILY ASSUME ALL RISK(S) of participating in Equine Assisted Therapy.

WAIVER AND RELEASE OF LIABILITY. By signing this release, I am releasing Backcountry Therapeutics, LLC and its employees, instructors, therapists, volunteers, contractors, subcontractors, agents or otherwise from liability resulting from the negligence of myself, other participants, by-standers, observers, visitors, Backcountry Therapeutics, LLC employees, instructors, therapists, volunteers, contractors, subcontractors, agents or otherwise.
I hereby voluntarily RELEASE, forever DISCHARGE, and agree to INDEMNIFY and HOLD HARMLESS Backcountry Therapeutics, LLC from any and all claims, demands, or causes of action, which are in any way connected with my participation in these activities or my use of equipment, horses, and facilities, including any such claims which allege negligent acts or omissions of Backcountry Therapeutics, LLC.
I have read and understand Alaska Statute 09.65.145 (available upon request) which refers specifically to liability for injuries or death resulting from livestock activities, which includes Equine Assisted Therapy. In accordance with section (g) of that statute, I am agreeing to waive my entire right to recover damages resulting from an inherent risk of a livestock activity.
FITNESS TO PARTICIPATE. I certify and represent that I do not have any medical or physical condition(s) that could interfere in any way with my participation in Equine-Assisted Therapy activities. If I do have any such conditions, I have disclosed them to Backcountry Therapeutics, LLC and I understand I may be at greater risk for injury or death and accept and assume all risks and indemnify and hold Backcountry Therapeutics, LLC harmless for any injury, illness, death or other loss created directly or indirectly by such physical or mental conditions.

CONSENT. Backcountry Therapeutics, LLC has discussed with me the nature of Therapeutic services I will be receiving, any alternatives, benefits, consequences and risks. Having this information in mind, I consent to receive such services and/or treatment.
This waiver is intended to be as broad and inclusive as permitted by the laws in Alaska. If any portion is held invalid the remainder of the waiver will continue in full force. I agree that any claims for injuries for damages, shall only be filed or maintained in an Alaskan Court, situated in Anchorage, Alaska. In the event that Backcountry Therapeutics, LLC or anyone acting on their behalf, is required to incur attorney fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

By signing this document, I acknowledge that if anyone is hurt or killed or property is damaged during my participation in these activities or my use of the premises or facilities or equipment, I may be found by a court of law to have waived my right to maintain a lawsuit against Backcountry Therapeutics, LLC on the basis of any claim from which I have released them herein.

BY SIGNING BELOW, I ACKNOWLEDGED THAT I HAVE HAD SUFFICIENT OPPORTUNITY TO READ THIS ENTIRE DOCUMENT. I HAVE READ AND UNDERSTOOD IT, AND I AGREE TO BE BOUND BY ITS TERMS.

Participant's Name _____ Date_____

Participant's Signature_____

Parent / Guardian Signature_____Date_____
(If participant is under 18 years old, Parent or Guardian must sign)

Emergency contact name _____Phone number_____

7200 Jim Cottrell Circle, Palmer, AK 99645 Phone: (907) 982-3897 Fax: (866) 283-2986

RELEASE, WAIVER OF LIABILITY, AND INDEMNIFICATION AGREEMENT

I, _____, on behalf of myself and/or my minor child, _____,
(Name) (Child's Name)

wish to utilize the services, facilities and therapeutic pool offered by Backcountry Therapeutics, LLC, and make the following voluntary agreements:

ASSUMPTION OF RISKS. I specifically acknowledge that the inherent risks associated with Pediatric Occupational Therapy services offered by Backcountry Therapeutics, LLC include but are not limited to: slips, falls, tripping, impacting a wall, and impacting other participants, impacting objects, allergic reactions, bruised or broken bones, choking, head injuries, paralysis and even death. If I am using aquatic therapy services additional risks are present and include: getting water in my mouth, eyes and ears, red or irritated eyes, dry, itchy or irritated skin, allergic reactions, aspirating water, and drowning. These risks are inherent in the participation of Pediatric Occupational Therapy and therefore cannot be eliminated. I understand these risks and expressly agree and promise to accept and assume all the risks of participating in Pediatric Occupational Therapy with Backcountry Therapeutics, LLC.

VOLUNTARY PARTICIPATION. I am voluntarily participating at my OWN RISK. I understand that serious accidents can and do occur. I understand that Backcountry Therapeutics, LLC and its employees, instructors, therapists, volunteers, contractors, subcontractors, and agents seek the safety of all participants but WE ARE NOT INFALLIBLE. Equipment, gear or aids may fail and cause serious injury or death. We may misjudge the nature, character, skills and abilities of a participant. We may fail to give adequate warnings or instructions, and we cannot always be in close enough proximity to prevent or minimize every injury or accident. I understand and acknowledge that I have a personal responsibility to follow all safety rules and procedures. I agree that my participation is voluntary and I VOLUNTARILY ASSUME ALL RISK(S).

WAIVER AND RELEASE OF LIABILITY. By signing this release, I am releasing Backcountry Therapeutics, LLC and its employees, instructors, therapists, volunteers, contractors, subcontractors, agents or otherwise from liability resulting from the negligence of myself, other participants, by-standers, observers, visitors, Backcountry Therapeutics, LLC employees, instructors, therapists, volunteers, contractors, subcontractors, agents or otherwise.
I hereby voluntarily RELEASE, forever DISCHARGE, and agree to INDEMNIFY and HOLD HARMLESS Backcountry Therapeutics, LLC from any and all claims, demands, or causes of action, which are in any way connected with my participation in these activities or my use of equipment, and facilities, including any such claims which allege negligent acts or omissions of Backcountry Therapeutics, LLC.

FITNESS TO PARTICIPATE. I certify and represent that I have disclosed any physical or mental conditions that may impair my ability to participate in Pediatric Occupational Therapy and I understand I may be at greater risk for injury or death and accept and assume all risks and indemnify and hold Backcountry Therapeutics, LLC harmless for any injury, illness, death or other loss created directly or indirectly by such physical or mental conditions. 8

CONSENT. Backcountry Therapeutics, LLC has discussed with me the nature of Therapeutic services I will be receiving, any alternatives, benefits, consequences and risks. Having this information in mind, I consent to receive such services and/or treatment.

This waiver is intended to be as broad and inclusive as permitted by the laws in Alaska. If any portion is held invalid the remainder of the waiver will continue in full force. I agree that any claims for injuries for damages, shall only be filed or maintained in an Alaskan Court, situated in Anchorage, Alaska. In the event that Backcountry Therapeutics, LLC or anyone acting on their behalf, is required to incur attorney fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

In the event that Backcountry Therapeutics, LLC or anyone acting on their behalf, is required to incur attorney fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

By signing this document, I acknowledge that if anyone is hurt or killed or property is damaged during my participation in these activities or my use of the premises or facilities or equipment, I may be found by a court of law to have waived my right to maintain a lawsuit against Backcountry Therapeutics, LLC on the basis of any claim from which I have released them herein.

BY SIGNING BELOW, I ACKNOWLEDGED THAT I HAVE HAD SUFFICIENT OPPORTUNITY TO READ THIS ENTIRE DOCUMENT. I HAVE READ AND UNDERSTOOD IT, AND I AGREE TO BE BOUND BY ITS TERMS.

Participant's Name _____Date _____

Participant's Signature _____

Parent/Guardian Signature_____Date_____
(If participant is under 18 years old, Parent or Guardian must sign)

Emergency Contact Name_____ Phone Number_____