



Therapeutic Riding of the Ozarks

627 N. Glenstone
(417) 862-3586 ext. 230

NOTICE OF PATIENT INFORMATION PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Therapeutic Riding of the Ozarks uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities; fund raising and grant writing; and evaluating the quality or care that we provide. For example, we may use your personal health information to contact you to provide schedule reminders, be included in statistics for fundraising, or provide other health related benefits that could be of interest to you.

Therapeutic Riding of the Ozarks may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We also provide information when required by law.

In any other situation, **Therapeutic Riding of the Ozarks** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosure at any time.

Therapeutic Riding of the Ozarks may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted and will be provided to you on your next visit. You may also request an updated copy of your Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Therapeutic Riding of the Ozarks** will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that **Therapeutic Riding of the Ozarks** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact **Director Kent Crumpley** at the address listed at top of page. You may also send a written complaint to the US Department of Health and Human Services. For further information on **Therapeutic Riding of the Ozarks** health information practices or if you have a complaint, please contact **Director Kent Crumpley**.



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PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand **Therapeutic Riding of the Ozarks Notice of Information Practice**. I understand that **Therapeutic Riding of the Ozarks** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. “I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Therapeutic Riding of the Ozarks** will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in **Therapeutic Riding of the Ozarks Patient Information Acknowledgment**, which I have received. I understand that I retain the right to revoke this consent by notifying **Therapeutic Riding of the Ozarks** in writing at any time. I understand this information will follow the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in regard to release of medical records and file records. (See Attached Release Form)

Patient Name _____

Signature of Patient or Parent/Guardian: _____

Date _____

To: _____
Health Care Provider

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND FILE RECORDS

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. §164.508, you are hereby directed to furnish to _____ any information requested by them including, but not limited to:

- * Hospital Records
- * Physical Therapy Records
- * X-Rays
- * Test Results
- * Nurse's Notes
- * Ledger Cards
- * EMT Reports
- * Billing Slips/Forms
- * File Notes
- * Emergency Room Records
- * Medical Records
- * Progress Reports
- * Doctor's Notes
- * Hospital Admissions/Discharges
- * Insurance Forms (Health, Workmen's Compensation, etc.)
- * Pharmacy Records
- * File Correspondence
- * Administrative File

or any other data in your possession, including your complete records file, which is related to my whole body, and permit the reproduction thereof, from _____ to present.

The purpose of this authorization and request is to allow _____ to access and obtain all medical records and other documents related to the aforementioned areas and conditions of my body and mind. You may discuss my condition, care and treatment with a representative of _____.

Except to the extent that action has already been taken in reliance on this authorization, I can revoke this authorization at any time by submitting a notice in writing to the health care provider named above.

Unless revoked, this Authorization will expire one (1) year from today's date shown below.

I understand that my medical or billing records may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or other sensitive information, and I agree to its release.

I understand that the information disclosed by this authorization may be re-disclosed by the recipient and no longer be protected by HIPAA of 1996. The above-named health care provider and all of its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand the health care provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

A copy of this Authorization shall be regarded as an original.

Patient Information

Name: _____ SSN: _____ DOB: _____

Patient Signature

Today's Date: _____



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PATIENT PROFILE

PATIENT

Name: _____ DOB: _____

Patient SS#: _____

Address: _____

Home Phone: _____ Work Phone: _____

Email: _____

Parent/Guardian Name (Or Emergency Contact): _____

Additional Phone: _____

Patient Diagnosis: _____ Height: ____ Weight: ____

Date of Onset: _____ Description of Injury or Illness: _____

Medications (type and amount): _____

Seizure Activity (type and frequency): _____

Allergies or Other Health Concerns: _____

Primary Treatment Concerns: _____

Primary Physician: _____ Phone #: _____



Therapeutic Riding of the Ozarks

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Springfield, MO 65808-3947

417.862.3586 ext: 230

Fax 417. 862.2129

kcrumpley@cozarks.org

www.trozarks.blogspot.com

Physician Referral for PT, OT and or SLP Therapy

Client: _____ DOB: _____

Primary Dx: _____

Secondary Dx: _____

Check all that apply: OT PT SLP

Evaluate and treat, to include Hippotherapy as a treatment tool for the duration of 2009 program year (April 2009 – November 2009). Unless otherwise stated below.

Physician's name: _____

Address: _____

Telephone: _____ Fax: _____

Physician's signature: _____ Date: _____

Please Fax To : (417) 862 – 2129



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MEDICAL AUTHORIZATION

Patient Name: _____ DOB: _____

Address: _____
Street or PO Box City State Zip

I hereby grant my permission for the following named agencies to release all records pertaining to the above named individual's relevant health history, diagnosis and previous or ongoing treatment services/documentation to **Therapeutic Riding of the Ozarks**. I understand this information will follow the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in regard to release of medical records and file records. (See Attached Release Form)

Agency Name _____

Address _____

Telephone _____

Agency Name _____

Address _____

Telephone _____

Signed _____ Date _____
Patient or Legal Guardian/Agent



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FINANCIAL RESPONSIBILITY STATEMENT

Patient

Name: _____ DOB: _____

Patient SS#: _____ Diagnosis: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Financially Responsible Party/Relationship to Patient: _____

Financially Responsible Party's SS#: _____

Mailing Address: _____

If different than above

Physical Address: _____

Employer: _____ Phone: _____

Employer Address: _____

Nearest Living Relative/phone: _____

Patient/Responsible Party's Signature: _____ Date: _____

Our published rate for an individual therapy lesson is **\$80 per hour** by private pay. ***There will be a \$55 charge for each additional written therapy report needed by patient's families.*** Prior to generating a report, the therapists serving your child will advise the family of this charge. This of course does not include the service sheets that are generated at the time of each therapy session.

Our cancellation policy requires 24-hour notice unless there is an emergency such as sudden illness, car trouble, etc. ***Failure to notify us of a cancellation will result in an \$80 charge for the missed session.*** Please notify your therapist @ their number as well as the Director of Therapeutic Riding of the Ozarks. _____ Initial here

We always advise our patients and families if we are going to be closed for holidays or for inclement weather. ***If we have not notified our patients and families of a closing, understand that we are on our regular therapy schedule.*** During bad weather, we make a decision by 7:30 am about abbreviated days or canceled days and notify our regularly scheduled patients.

I have read and understand the above stated financial policies: _____

Patient or Patient's Guardian Signature

Date _____



Therapeutic Riding of the Ozarks

Consent Form

I, _____ understand that my insurance may not
reimburse me for Hippotherapy as a treatment tool.

Name: _____ Date: _____ .

Signature: _____ Date: _____ .



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PATIENT GRIEVANCE PROCEDURE

It is the intent of the staff at **Therapeutic Riding of the Ozarks** to provide all of its patients with high quality treatment services appropriate to their needs. If at anytime, a patient, his or her family, or those individuals providing guardianship or supervision for a patient have a complaint pertaining to any and all aspects of the services provided at **Therapeutic Riding of the Ozarks**, they are requested to put said complaint in writing to the **Director, Kent Crumpley**. Any such written complaint will be responded to within a two week period of time, both in writing and through personal contact if such contact can be made.

Patient/Parent or Guardian Signature

Patient Name

Date

Insurance Reimbursement

Therapy Services at Therapeutic Riding of the Ozarks (TRO) proudly offers Physical and Occupational Therapy Services for children and adults. We specialize in the use of Hippotherapy/Equine Movement as part of a comprehensive treatment plan. We request payment at the time of service, and do not currently direct bill insurance companies for payment. Upon receipt of payment for services to TRO, we offer statements/receipts to our patients that may be used to seek reimbursement from their insurance company.

Please note the following:

- Not all insurance companies will reimburse for services received and you are responsible to attain verification from your insurance company, based on the specifics of your policy, whether or not they will reimburse for PT or OT.

- Some insurance companies have specific exclusions or rules relating to therapy services provided. It is the responsibility of the insured to obtain the specifics of these potential exclusions from their insurance company.

- Most insurance companies have requirements of paperwork (i.e. doctor prescription or letters of medical necessity). If this is the case, please notify the therapists at TRO to assist you in obtaining the required paperwork.

- Attached please find a suggested procedure to use when contacting your insurance company.

If you have any questions, please feel free to contact the therapists at TRO and we will be happy to assist you.

I, _____ understand that my insurance company may
(Please print name)

not reimburse me for hippotherapy as a treatment tool.

Signature: _____ Date: _____

**INSURANCE VERIFICATION OF BENEFITS
SUGGESTED QUESTIONS TO ASK....**

Therapy Services as Therapeutic Riding of the Ozarks (TRO) is committed to helping our patients and their families. Your insurance company may reimburse for Physical or Occupational Therapy but you will need to find out your specific plan details. Always make a note of the time and date you called your insurance company, the person you spoke with, and the questions asked and answers given!

When you call, be ready to present the following – 1) The Name of Insured; 2) Insured's place of employment; 3) Insurance Group Number; 4) Insured's ID number (usually his/her SS#) and 5) Name of person requiring therapy, their relationship to the Insured, and their referring doctor and diagnosis. Preview the questions below and then write in the answers!

INFORMATION TO GIVE AND QUESTIONS TO ASK

A. I'm calling to verify benefits for outpatient physical or occupational therapy services for _____ (patient's name and relationship to insured). I have a prescription from Dr. _____ with the diagnosis of _____.

B. I am seeking Physical or Occupational Therapy services from an outpatient center named **Therapeutic Riding of the Ozarks**. Am I covered if **TRO** is a non-participating provider or an out-of-network provider? If **NO**, Can I submit my therapy receipts for reimbursement? _____ If **YES**, Are there any special forms that need to be completed? _____

C. What are my deductible and/or co-pay? _____

D. Does my policy limit the number of visits per year? **NO YES** (list #) _____

E. Does my policy have a cap on the amount of money paid out per year? **NO YES** \$ _____

F. What services are covered or **is any specific service excluded?** _____

G. CPT evaluation codes used are 97003, 95851, 97750, 95831, 96110, and 96115. CPT treatment codes are 97110, 97112, 97124, 97139, 97265, 97530, 97532, 97533, 97535, 97799, and 99499. Are any of those codes excluded in coverage? **NO YES** _____

Are there limits of use on any of those codes? **NO YES** _____

H. Do I need Pre-authorization or Pre-certification? **NO YES** _____

I. Is RE-certification needed? **NO YES** After how many treatment sessions? _____

J. Are there any exclusions to my policy: Is treatment limited to a new illness or injury, does it cover my diagnosis, will it cover therapy if it is not administered in a hospital affiliated center, do I need to be receiving Physical Therapy for Occupational Therapy to be covered? _____

K. What are the billing instructions? _____

What information do I need to submit? _____

Do you accept a Super bill completed by my therapist? **YES NO**

L. Where do I submit it? (Complete Billing Address) _____

M. Is there a contact person I can call if I have any follow-up questions about my case?

(NAME)

(TELEPHONE #

EXTENSION #)

We look forward to serving your therapy needs and hope this questions sheet has been helpful!

Sincerely,

Therapy Services at Therapeutic Riding of the Ozarks

627 N. Glenstone, Springfield, MO 65808- 417.862.3586 ext 230- 417.862.2129 f- www.trozarks.blogspot.com