TRIANGLE
THERAPY SERVICES

Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Triangle Therapy Services to:

1. Secure and retain medical treatment and transportation if needed.
2. Release any records upon the request to the authorized individual or agency involved in the medical emergency treatment.

Please describe any medical conditions that may require special precautions or treatment and any medications you are now taking:

_____

_____

List any allergies: _____

Client's Name: _____ Date of Birth: _____

Parents/ Guardian: _____

Address: _____

_____

Primary phone: _____Name: _____

Other phone: _____ Name: _____

Email: _____ You may contact me by email: Y or N

Physician's Name: _____ Telephone #: _____

Person to contact in emergency (if parent or guardian cannot be reached first):

_____ Contact #: _____

Person your child may be released to (if parent or guardian cannot be reached first):

_____ Contact #:_____

Signature Date Relationship

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Registration and General Release Form

I, _____ (Parent/Legal Guardian's Name), hereby apply for participation in Triangle Therapy Services, LLC summer programs or hippotherapy program. I acknowledge the risks and the potential for risks of the program's use of horses, other animals, and nature activities. However, I feel that the possible benefits are greater than the risks assumed. I hereby forever release, discharge, and hold free and harmless, for myself, my heirs and assign, executors or administrators, all claims for damages against Triangle Therapy Services, LLC, its therapists, instructors, aides, volunteers, and /or employees, and the Benge Farm of any and all injuries and/or losses the client, client's family, or guests may sustain while participating in any programs.

_____ _____

Signature of Parent/Legal Guardian Date

Photo Release

I consent to and authorize the use of reproduction by Triangle Therapy Services, LLC of any and all photographs and any other audiovisual materials take of the client, client's family, or guests while in treatment for use in promotional materials, educational activities, exhibitions, or for any other use of the benefit of Triangle Therapy Services, LLC. I also give consent for pictures (without names) to be posted on the Triangle Therapy Services, LLC Facebook, Pinterest, YouTube, and Instagram pages.

_____

Signature of Parent/Legal Guardian Date

Damage Release

I, _____ (Parent/Legal Guardian's Name), hereby agree that I will be responsible for seeing that any children or guests brought by me on the premises of Triangle Therapy Services, LLC are properly supervised at all times while on such premises. I agree to not bring any animals onto the property. I further agree that I will be liable for any damage to the property of Triangle Therapy Services, LLC or the Benge home, and/or for any loss of use of such property resulting from any such damage, caused by my negligence or that of any child or guest brought on such premises by me. I further agree to pay for any necessary repairs or to reimburse Triangle Therapy Services, LLC and/or the Benge family for the reasonable cost of repair, replacement, and/or loss of use of such property pending repair or replacement.

_____

Signature of Parent/ Legal Guardian Date

TRIANGLE
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Consent for Services

Name of Client: _____ D.O.B: _____

Address: _____
Street or PO Box City State Zip

I hereby grant my permission for the above named client to receive treatment services at Triangle Therapy Services as they have been outlined to me. I have received a copy of the Facility Policies and understand the nature of the service that I will receive. By initialing the following items, I acknowledge the policies at Triangle Therapy Services, and my responsibilities as stated below:

MEDICAL INFORMATION AUTHORIZATION: I hereby give my consent to any physician, hospital, school or clinic to release any and all records pertaining to medical history, services, or treatment as it applies to my treatment services at this facility. This information will be treated as confidential. I also give my consent for Triangle Therapy Services to release information relating to my diagnosis/treatment at this facility to my insurance carrier, my physician, school, or other agencies that I may designate.
_____(Initial here)
I acknowledge that I have received Notice of Protected Health Information Practices according to the Health Insurance Portability and Accountability Act (HIPAA)
_____ (Initial here)

FINANCIAL RESPONSIBILITY: I authorize billing and payment of medical benefits to Triangle Therapy Services, LLC from my insurance company. However, I assume full financial responsibility for the therapy services that I will receive, regardless of third -party coverage. I assume full financial responsibility in the event that my health carrier denies insurance payment in part or in full. I understand fees for service, co-pays, or co-insurance are due at the time therapy services are rendered unless other arrangements have been made.
_____(Initial here)

CANCELLATIONS/MAKE-UPS: I understand that if I must cancel a session, a 24-hour notice is required. A $25.00 no show fee may be charged. Payment is due prior to returning to therapy and a loss of appointment time (placed on wait list) after 2 no shows.
_____(Initial here)

CONSENT FOR PICTURE AND VOICE: I hereby acknowledge that photographs, slides, videotape footage, and/or audio recordings may be made of my therapy sessions at Triangle Therapy Services. I waive my rights to privacy so that members of my family, and/or professional staff may observe these media, which will be used for analysis to improve and document treatment. They may also be used for educational purposes, research purposes, and for the purpose of training other professionals to better understand special needs and treatment methods. They may be posted on the Triangle Therapy website or Triangle Therapy face book page for public information purposes without names being used.

Permission given: Yes No (circle one)
_____ (Initial here)

The undersigned certifies that he/she has read the above and has received a copy of the Facility Policies. The undersigned also certifies that he/she is the client or is the duly authorized client guardian and can execute the above and accept its terms on behalf of the client.

Client or Client's Parent/Guardian Signature: _____ Date: _____

TRIANGLE
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Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization**. COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.
Triangle Therapy Services, LLC (TTS) has put in place preventative measures to reduce the spread of COVID-19; however**, TTS cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, **attending therapy sessions could increase** your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending therapy and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I have reviewed and agree to the preventive measures put in place by TTS as communicated by letter and posted. I can also request a copy of preventive measures. I understand that the risk of becoming exposed to or infected by COVID-19 at TTS may result from the actions, omissions, or negligence of myself and others, including, but not limited to, TTS employees, volunteers, program participants and their families. I acknowledge that teletherapy continues to be an option to receive therapy services.

_____ _____
Parent/Guardian signature Date

_____
Client name

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Physician Referral

Client's Name _____ Date of Birth: _____

Parent's Name _____

Address _____

Cell: _____ Home phone_____

Diagnosis and ICD-10 code: _____

Pertinent Medical history: Please list any information the therapist should know in treating this client (seizures, contraindications, medication):

_____
_____
_____

Therapy Services Requested (please check)

Occupational Therapy ___Evaluation only ___ Evaluation and treatment

Physical Therapy ___Evaluation only ___ Evaluation and treatment

Speech Therapy ___Evaluation only ___ Evaluation and treatment

_____ _____ _____
Doctor's signature Date NPI #

_____
Doctor's name (printed)

Address: _____

Phone # _____ Fax # _____

Triangle Therapy Services, LLC** 911 West Main St. Eaton, Ohio 45320
Phone: 937 456-6505 ** Fax: 937 456-6507