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: _____

Secondary 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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TRIANGLE
THERAPY SERVICES

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 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 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

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TRIANGLE
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Consent for Services

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

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 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/NO-SHOW POLICY: Please call the office 24 hours in advance if you need to cancel your child's therapy appointment; however, we realize that sometimes children wake up sick and you will not be able to provide the 24-hour notice. The NO-SHOW fee is $25.00 per no-show and this fee will be reflected on your monthly invoice. Once tow no-shows occur, your child will be removed from their weekly therapy time slot and placed back on our waitlist.
_____ (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: _____

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TRIANGLE
THERAPY SERVICES

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

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Welcome to Triangle Therapy Services. Do not hesitate to ask for assistance if you have questions. Please read the following general information and guidelines:

1. Paperwork: All forms should be completed and signed before your child is seen.

2. Scheduling: All clients are seen by appointment only. A physician's prescription is required for all clients prior to the first appointment. Prescription should specify occupational, physical, or speech therapy evaluation and treatment.

3. Cancellations/ No-Shows: If you need to cancel an appointment, please notify us at least 24 hours prior to your scheduled time; rescheduling may be an option. A $25.00 no show fee will be charged for no-shows and this fee will be applied to you monthly invoice. A loss of appointment time will happen after 2 no shows and your child will be placed back on the waitlist **Triangle Therapy will be closed for weather if Eaton Community Schools close. We will not follow school delays unless your therapist contacts you.** If the driveway is deemed unsafe, clients will be contacted for cancellation by their therapist.

4. Observing Therapy: We are happy to have the families and friends of clients observe treatment as long as it does not distract the client or other client's therapy. In order to keep the integrity of the session we ask that you do not interrupt or distract the client during therapy.

5. Therapy Format Sessions: Length of session will be determined on an individual basis. As a general format, therapy sessior are scheduled in 30-, 45-, or 60-minute blocks. This includes time at the end for communication time with the, family/caregivers and 5 minutes of documentation time.

6. Supervision of Children: Other children may accompany parents to a therapy session. Parents are responsible for supervision at all times. Children **may not** be in the barn or in the woods without a therapist or on the playground without an adult. If the integrity of the session is being compromised by the presence of others, parents will be notified.

7. Payment Procedures: Arrangements for insurance billing must be made prior to beginning therapy sessions. A cash discount is provided for private payment. Co-pays or private payment should be paid each session. Credit cards are require to be on file, and Health Savings accounts are accepted for client convenience. Accounts not paid within 60 days are subjec to a 1.5% finance charge, and your credit card will be charged your balance due. If your family accumulates a balance of $500 or more, your child will be placed on hold. Please reach out to us so arrangements can be made.

8. Pets: Due to our commitment to the safety of our clients and animals, **NO pets** are allowed on the premises. You may pet our goats, from outside the barn, at your own risk, but please be aware that the electric fence is on. Please do not allow children to tease, touch, or feed the animals. You are **not** permitted to pet our horses.

9. Parking: Please park on the pavement in front of the barn (please park perpendicular to the front of the barn) or in the gravel lot west of the barn. The office door is located on the NW corner of the barn and is marked accordingly. Please observe a safe speed limit in the driveway as there may be children or animals about. Please respect the private residence on the property and neighboring homes. Please **do NOT** drive around the circle drive near the house.

10. Rest Rooms: A w/c accessible bathroom is available inside the finished office space.

Please bring all completed paperwork and physician's prescription to your first appointment!!

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Credit Card Authorization Form

Please complete all fields on this form. This credit card authorization form will remain in effect until it is cancelled. You may cancel this authorization at any time. Triangle Therapy Services will accept alternate means of payment for charges upon written request. Direct all inquiries to info@triangletherapyservices.com.

CREDIT CARD INFORMATION
Card Type: Mastercard Visa Other: _____
Cardholder Name (as shown on card): _____
Card Number: _____ **Expiration Date: ____/_____** **3-digit security code: _____** **Zip Code: _____**
Cardholder Phone Number: _____ **Cardholder Email Address: _____**

I, _____, authorize Triangle Therapy Services, LLC to charge the above listed credit card for associated charges relation to provision of services by Triangle Therapy Services, LLC including but not limited to: deductible, co-payment, and no-show or late cancellation fees. I understand that my credit card information will be saved in a protected format for future transactions.

_____ _____

Cardholder Signature **Date**

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Client History Form

Please fill out this form as completely as you can.
Your therapist may ask you additional questions to clarify or expand information.

Date: _____

I. Patient Information

Client's Name: _____ Date of Birth____/_____/_____
Parent/Guardians Name: _____
Address: _____
Primary Phone Number: _____ Secondary Phone Number: _____
Physician: _____ Reason for referral: _____
Diagnosis, if any: _____
Allergies: _____
Medical Precautions: _____
Dietary Restrictions: _____
Medications: _____
Who lives in the household with your child? _____
_____
Brief description of your home and routine: _____
_____
What are your main concerns with your child: _____
_____
What does your child find enjoyable? _____
What are your child's gifts? _____

II. Prenatal and Birth History

Child was born: full-term____ premature____ Weeks of pregnancy _____ Birth weight _____
Delivery: vaginal _____ forceps _____ vacuum _____ C-section____
Was your child placed in the Intensive Care Unit? _____ If so, how long? _____
Please describe any prenatal medical problems or complications at birth: _____
_____

III. Developmental Milestones – (mark approximate month)

Rolled over_____ Crawled_____ Sat alone_____ Crawled _____ Pulled to stand _____
Walked alone_____ Babbled_____ First word_____ Used spoon_____
Drank from a cup_____ Toilet trained_____
Comments _____
_____
_____

IV. Medical History (please include dates)

Hospitalizations: No _____ Yes_____ If yes, please describe _____

_____

Surgical Procedures: _____

Previous psychological evaluation: No ____ Yes_____ If yes, please describe_____

Equipment your child uses: Splints_____ Braces_____ Adaptive utensils_____ Walker_____ Wheelchair _____

Describe: _____

Please check all that apply to your child:

___Hearing aids ___Hearing difficulty ___Ear Tubes ___Chronic ear infections

___Vision difficulty ___Vision testing ___Glasses ___G-tube ___ Seizures _____

Please list any information regarding ear infections, enlarged tonsils or adenoids, mouth breathing

_____

Additional Comments: _____

V. School History/ Previous Therapy

School/Educational program currently attending and grade: _____

Special services received in school (include teacher/therapist if known):

OT _____ PT _____ Speech _____ Special Education _____ Behavior Intervention _____

Other special service ____ Please list: _____

Does your child's teacher have concerns with your child's development in any of the following areas?

Motor skills_____ Social abilities _____ Self-help skills_____ Learning abilities _____

School history including preschool and early intervention _____

_____

Previous Therapy _____

_____

Additional Comments: _____

VI. Sensory Processing

Please check any of the following that apply to your child:

___ Cries often
___ Dislikes face/hair brushing
___ Clumsy
___ Dislikes tooth brushing
___ Anxious
___ Rocks self
___ Mouths objects
___ Grinds teeth
___ Seems to be "on the go"
___ Poor attention span
___ Weak muscles
___ Sensitive to light
___ Picky eater
___ Trouble with directions
___ Sensitive to sound
___ Avoids touch from others
___ Trouble with transitions
___ Crave jumping/crash play
___ Trouble attending to task
___ Dislikes playground
___ Difficulty sleeping

VII. Social/Emotional Development

Does your child interact well with others ____Yes ____ No

Does your child have any trouble making friends? ____ Yes ____ No

Does your child have difficulty calming when upset ___Yes ____ No

Fears, Coping behaviors: _____

Additional comments: _____

VIII. Speech History

Does your child use eye contact with you/others? _____Does your child socially engage with you/others with smiles & nonverbal interaction? _____

Did your child babble and coo? _____ First words were before 18 months _____ or after 18 months _____

When did your child begin to combine words into simple phrases or sentences: _____

Please give examples of common word/sentences your child uses: _____

_____

If your child uses signs, please list the signs they know or use purposefully: _____

_____

What percentage of your child's speech do you understand? _____ Strangers? _____

Any concerns with stuttering? _____

Any history of cleft lip/palate or dental anomalies? _____

IX. Feeding History

Early feeding: bottle/breast/both (until what age) _____

Any difficulties with early feeding _____

Any problems with (describe below):

___Gagging ___Choking ___Reflux ___Excessive Drooling ____Food Stuffing ___Pocketing/holding ___

Puree foods ___Solid Foods ___Cup Drinking ___Straw Drinking ___Self-feeding ___Picky Eater ____Utensil Use

Please describe marked items: _____

Any nutritional concerns? _____

Food Preferences/Dislikes (Taste, Texture) _____

X. Self-Care (please describe status in the following areas)

Toileting: _____

Grooming (Teeth, hair, bathing): _____

Undressing: _____

Dressing: _____

Buttons/Zippers: _____

Shoes/Socks: _____

Shoe tying: _____

Describe any other self-care challenges: _____

XI. Motor skills (please describe status in the following areas)

Ambulation status: _____

Gross motor (large muscle) challenges: _____

_____

Fine motor (small motor) challenges: _____

_____

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

_____ _____

Signature Date

Revised 9/2024