



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 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 #: _____

Emergency contact: (if parent or guardian cannot be reached first):

_____ Contact #: _____

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

_____ Contact #: _____

Signature _____ Date _____ Relationship _____

TRIANGLE THERAPY SERVICES

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 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 the 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 if 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-SHOWS: 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 24-hour notice. The NO-SHOW fee is \$25.00 per no show and this fee will be reflected on your monthly invoice. Once two no-shows occur, your child will be removed from their weekly 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.

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

Revised 2/2026



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 any other use of the benefit of Triangle Therapy Services, LLC. I also give consent for pictures (without names) to be posted on 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 always supervised 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 THERAPY SERVICES

Credit Card Authorization Form

Please complete all fields on this form. It is a requirement that this credit card form is filled out if you have a commercial insurance policy. This credit card authorization form will remain in effect until it is cancelled by the practice or your information has expired. 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

TRIANGLE THERAPY SERVICES

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	<input type="checkbox"/> Evaluation only	<input type="checkbox"/> Evaluation and treatment
Physical Therapy	<input type="checkbox"/> Evaluation only	<input type="checkbox"/> Evaluation and treatment
Speech Therapy	<input type="checkbox"/> Evaluation only	<input type="checkbox"/> Evaluation and treatment

Doctor's signature _____ Date _____ NPI # _____

Doctor's name (printed)

Address: _____

Phone# _____ Fax# _____

TRIANGLE THERAPY SERVICES

Facility Policies

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 your monthly invoice. A loss of appointment time will happen after 3 no shows and your child will be placed back on the waitlist.
Triangle Therapy will be closed for the 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 if it does not distract the client or other client's therapy. 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 sessions 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. Parents/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-pay or private payment should be paid each session. Credit cards are required to be on file, and Health Savings accounts are accepted for client convenience. Accounts not paid within 60 days are subject to a 1.5% finance charge, and your credit card will be charged your balance due. If your family accumulates a balance of \$300 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: The gravel parking lot West of the building is for Triangle Therapy. We ask that you observe a safe speed limit in the driveway as there may be children or animals around. Please use the circle drive for drop-off and pick up beside the building. Please park your vehicle in a lined space next to the field while your child is in their therapy session. Handicapped parking is located at the front of the building for clients in wheelchairs or who have mobility deficits. 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.

Revised 1/2026