

QUEST THERAPEUTIC SERVICES, INC.

461 Cann Rd.

West Chester, PA 19382

Phone (610) 692-6362; Fax (610) 692-0917

Welcome to Quest Therapeutic Services, Inc., a hippotherapy center. Please complete all the attached forms as thoroughly as possible. Do not hesitate to ask for assistance! Please read the following information and guidelines.

- 1. Paperwork** - All forms should be completed and signed. Please bring the completed paperwork, physician's prescriptions, and copy of insurance cards to your first appointment or fax to Quest at above fax number prior to first appointment.
- 2. Scheduling** – All patients are seen by appointment only. A physician's prescription is required for all patients prior to first appointment.
- 3. Cancellations** – Since part-time employees and volunteers are scheduled for each patient, cancellations are difficult for us. If you need to cancel an appointment, please notify us at least twenty-four (24) hours prior to your scheduled time. If an appointment is missed without prior notification, we hold the right to assess a \$35.00 charge. This charge will not be reimbursed by your insurance company.
- 4. Supervision of Children** – Children are welcome to come to the therapy sessions, but please keep a close eye on them at all times. Due to safety factors, they must be with an adult at all times and remain reasonably quiet.
- 5. Touring Facilities** – You are welcome to enjoy the view of the farm and walk the property.. Safety precautions and consideration need to be exercised at all times.
- 6. Payment Procedures** – Payment is due within 45 days of service. Any charges that your insurance does not cover within forty-five (45) days and any deductible or copay is the immediate responsibility of the patient/parent/guardian. Since we run on a very tight budget, service will be discontinued for any balance that becomes delinquent.
- 7. Pets** – There are several friendly barn dogs. You may pet these animals at your own risk. Please don't allow children to touch the animals without adult supervision.
- 8. Rest Rooms** – A rest room is available near the family waiting room.

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Date:	Patient's Name:		
() Male () Female	Date of Birth:	Social Security Number:	
Parent/Guardian Names:		Relation: () Parent () Grandparent () Guardian () Other	
Address:		E-Mail Address:	
Home Telephone: Cell phone:		Employer Name, Address, Work Phone Number	
Emergency Contact:		Telephone:	

INSURANCE INFORMATION

Primary Insurance Company Name:	
Claims Address:	
Telephone:	Case Manager/Contact:
Policy/Group Number:	ID Number:
Secondary Insurance Company Name:	
Claims Address:	
Telephone:	Case Manager/Contact:
Policy/Group Number:	ID Number:

Hours of operation: There may be a waiting list, but please circle and indicate your preference for times your child is available, and our office will contact you:

Monday	Tuesday	Wednesday	Thursday	Saturday
3:00 pm	3:00 pm	8:45 am	3:00 pm	9:00 am
3:45 pm	3:45 pm	9:30 am	3:45 pm	9:45 am
4:30 pm	4:30 pm	10:15 am	4:30 pm	10:30 am
5:15 pm	5:15 pm	11:00 am	5:15 pm	11:15 am
6:00 pm	6:00 pm	11:45 am	6:00 pm	12:00 pm
Notes:				

MEDICAL INFORMATION

Diagnosis:	Date of Onset:
Physician's Name:	Telephone:
Address:	
Is patient receiving therapy elsewhere? () Yes () No	If yes, where ?

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- ◆ **Assignment of Benefits** – I hereby authorize Quest Therapeutic Services, Inc. (QTS) to release any information, both medical and financial, which is requested by my insurance company, trust, or responsible agency in relation to payment of my account.

- ◆ **Payment of Account** – In most cases, it is your responsibility to submit claims for payment to your insurance company. Payment is due within 45 days of service. We accept cash, check, or Visa/Mastercard. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. This means that upon receiving a claim, your insurance company should pay you within 30 days. It is your responsibility to monitor that your insurance company is fulfilling the terms of its contract with you. Services not paid within 45 days are considered past due. We may charge interest in the amount of 1.5% monthly for balances due past 45 days. Any account balance that is delinquent may result in termination of services until account is made current.

- ◆ **Cancellation Policy** – QTS holds the right to assess a \$35.00 charge when a client fails to give twenty-four hours prior notice of cancellation of an appointment. This charge will be the sole responsibility of the patient, parent, or guardian and will not be reimbursed by your insurance company.

- ◆ **Consent to Photograph, Video** -- I hereby give QTS the right to photograph, televise, film, videotape and/or sound record the acts, appearances and utterances of _____ and to use any descriptive works or names, including the name of the above mentioned patient in connection therewith and without limit as to time, to produce and reproduce the same or any part thereof by any method and to use said photographs, teletypes, films, videotape and/or sound recording for any purpose which QTS deems proper in the interest of newspapers, television media, brochures, pamphlets, instructional material, books, and clinical material, medical education, knowledge, and/or research. All such photographs, teletypes, films, and/or sound recordings shall be the exclusive property of QTS and I hereby relinquish all right, title, and interest therein. With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of QTS, to use or cause to be used such photographs, films, and pictures for the primary purpose of promotion and aiding QTS, and its work.

- ◆ **Release Agreement** – The undersigned, individually or as parents and/or legal guardian of the below patient, for an in consideration of the agreement of Quest Therapeutic Services, Inc. to provide hippotherapy, physical therapy, occupational therapy, and/or speech therapy, do hereby forever release, acquit, discharge, and hold harmless Quest Therapeutic Services, Inc., their officers, trustees, agents, employees, representatives, successors, or assigns for all manner of claims, demands, and damages of every kind and nature whatsoever which the undersigned may now or in the future have against QTS and/or its officers, trustees, agents, employees, representatives, successors, or assigns on account of any personal injuries, physical or mental condition, known or unknown, to the individual listed below and the treatment thereof as a result of or in any way associated with or growing out of the acts of QTS and/or their officers, trustees, agents, employees, representatives, successors, or assigns including, but not limited to, their negligence or gross negligence, in rendering the service above described or in any way incidental thereto.

Signature

Date

Patient Name

Relation if other than patient

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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 Quest Therapeutic Services, Inc, its officers, employees, and/or representatives 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 to medication you might have _____

PATIENT'S NAME: _____

DATE OF BIRTH: _____

PHYSICIAN'S NAME: _____

PERSON TO CONTACT IN EMERGENCY:

_____ TELEPHONE: _____

SIGNATURE

RELATIONSHIP IF OTHER THAN PARENT

Medical History

Has patient ever been diagnosed with the following:

- () Seizures () Diabetes () High Blood Pressure
 () Migraines () Heart Problems () Kidney or Liver Dysfunction
 () Cancer () Arthritis () Stroke or Vascular Problems
 () Other: Explain _____
