BEATS
www.BEATS-Inc.org

Mailing address: 1704 Winston Court Woodstock GA 30189
Facility address: 75 Red Gate Trail Canton Ga 30115
Email: bethany@beats-inc.org
Phone: 404-644-3917 Fax: 678-494-6616

DATE (mm/dd/yyyy)	

CLIENT INFORMATION

First Name		**Middle Initial**		**Last Name**			
Sex	Male ☐	Female ☐	**DOB** (mm/dd/yyy)		**Height** (in.)		**Weight** (lbs.)
Diagnosis	Primary		Secondary				
Date of Onset (mm/dd/yyyy)		**Hand Dominance**	Right ☐	Left ☐	Not Established ☐		
Allergies							
Language	Primary		Secondary, *if any*				
Ethnicity							

PARENT/GUARDIAN INFORMATION

Parent ☐	**Guardian** ☐	**Foster Parent** ☐					
Are parents married?	Yes ☐	No ☐	If no, who does child live with primarily?				
Mother's Name			**Father's Name**				
Mother's Cell			**Father's Cell**				
Email				**Home Phone**			
Street Address							
City		**State**		**Zip Code**			

EMERGENCY CONTACT

Name		**Relationship**		**Phone**	

HOME LIFE

Who else lives in the home?

Name		Age		Any significant health impairments?	Yes ☐	No ☐	
Name		Age		Any significant health impairments?	Yes ☐	No ☐	
Name		Age		Any significant health impairments?	Yes ☐	No ☐	
Name		Age		Any significant health impairments?	Yes ☐	No ☐	

Other significant contacts (Sitters or extended famliy outside of the home who help with care).

Name		Relationship	
Name		Relationship	
Name		Relationship	

School		**Grade**		**Special Ed Program**	Yes ☐	No ☐		

**Please submit current IEP (If applicable).*

Other non-therapy activities								
Are there stairs in the home?	Yes ☐	No ☐	**Any pets in the home?**	Yes ☐	No ☐			
Any concerns about home or community access?								

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PHYSICIAN INFORMATION

Referring Physician		Doctor's Group					
Address							
City		State		Zip Code		Phone	
Primary Physician		Doctor's Group					
Address							
City		State		Zip Code		Phone	
Specialist Physician		Doctor's Group					
Address							
City		State		Zip Code		Phone	

INSURANCE INFORMATION

Name of Primary Insurance			
Policy Holder		DOB (mm/dd/yyy)	
SSN		Relationship to Client	
Policy Number		Group Number	
Billing Address			
Provider Services Phone			
Name of Secondary Insurance			
Policy Holder		DOB (mm/dd/yyy)	
SSN		Relationship to Client	
Policy Number		Group Number	
Billing Address			
Provider Services Phone			
Name of Tertiary Insurance			
Policy Holder		DOB (mm/dd/yyy)	
SSN		Relationship to Client	
Policy Number		Group Number	
Billing Address			
Provider Services Phone			

INSURANCE AUTHORIZATION

I hereby authorize the release of any medical or other necessary information to BEATS, Inc. I also authorize payment of medical benefits to BEATS, Inc., for services rendered. I further agree that should the amount be insufficient to cover the entire expense, I will be responsible for payment of the entire bill.

Parent/Guardian Signature		**Date**	

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CONSENT OF TREATMENT

I do hereby consent for treatment by BEATS, Inc., I consent to care and treatment that falls within the scope of physical, occupational and speech therapy practices as defined by the State of Georgia. I understand that the practice of medicine, including physical and occupational therapy is not an exact science and that the treatment will involve physical participation on the part of the client which may involve risks of injury. I feel the possible benefits to myself, son, daughter or wards are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrator, indemnify, hold hairless, waive release forever all claims for damages against BEATS, Inc., its board of directors, therapists, aides, volunteers and employees for any and all injuries and loses including theft, loss of property or death that I, my son, daughter or ward may sustain while participating in the BEATS, Inc. program.

By signing this form, I acknowledge that I have read and understand the contents and am competent to execute it or if executed on behalf of another, that I am authorized to execute it on behalf of that person.

Parent/Guardian Signature		**Date**	

CONSENT FOR PAYMENT

I understand the hourly rate for physical, occupational or speech therapy is $200.00/session. I understand a yearly evaluation will be performed. I have read the above information regarding payment for therapy services by BEATS, Inc. and fully understand this information. I authorize BEATS, Inc., or their billing agent, to bill my appropriate third party payer for direct reimbursement of therapy services rendered to me/my child. Benefit payment will be assigned directly to BEATS, Inc. If payment is rendered to member, I will reimburse provider for amount paid and provide a copy of the accompanying Explanation of Benefits within two weeks of receipt. I understand that services will be put on hold, if I fail to reimburse member in a timely fashion. If I am uninsured, I will pay provider(s) in full prior to services being rendered. I will inform provider of any changes in applicable third party payer(s) that may occur.

Parent/Guardian Signature		**Date**	

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the following Person(s) or Facility(ies) to release information from the records of (you or your child here) _____

1) Person (s) or Facility (ies)	
2) Person (s) or Facility (ies)	
3) Person (s) or Facility (ies)	
4) Person (s) or Facility (ies)	

The information is to be released to BEATS, Inc. and any of the therapists/employees working under the auspices of BEATS, Inc. for the purpose of therapy services provided under BEATS, Inc.

The release is valid for one year and can be revoked, in writing, at my request

Parent/Guardian Signature		**Date**	

RELEASE OF INFORMATION

I hereby authorize BEATS, Inc. to release to all insurance companies only such therapeutic and financial information as may be necessary to determine benefits entitled to and process payment claims for therapy services that will be provided. I hereby authorize BEATS, Inc. to release to physicians and the Babies Can't Wait Program therapeutic and financial information as may be necessary.

Parent/Guardian Signature		**Date**	

PRIVACY PRACTICE AND PROCEDURES ACKNOWLEDGMENT

I understand that BEATS, Inc. may be provided access to, or create on my behalf, certain protected, indefinable, health information and that I have certain rights to the restriction of disclosure and use of such information. I hereby, acknowledge that on the date indicated below, I was presented with a copy of BEATS, Inc. HIPAA Notice of Privacy Practices pursuant to HIPAA and 45 C.F.R. Parts 260 and 164 and applicable state law. I have reviewed the Notice and understand its terms or have been provided an opportunity to have the same explained to me.

Parent/Guardian Signature		**Date**	

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PHOTO RELEASE

I hereby consent to and authorize the use and reproduction of any and all photographs and other audiovisual materials taken of me, my son, daughter or ward for promotional printed material and/or educational activities for BEATS, Inc. program.

Parent/Guardian Signature		**Date**	

RELEASE AND INDEMNIFICATION AGREEMENT

Be it known that under Georgia Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to Chapter 12 of Title 4 of the Official Code of Georgia Annotated.

_____(Client's Name) would like to participate in the Bethany's Equine and Aquatic Therapy Services, Inc (BEATS, Inc) program. I acknowledge the risks and potential for risks of horseback riding programs. However, I feel that the possible benefits to me/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, indemnify, hold harmless, waive and release forever all claims for damages against BEATS, Inc., its Board of Directors, Instructors,. Therapists, Aides, Volunteers and/or Employees, as well as the owners of the property, Mariposa Farms, LLC, their officers and family members, agents, employees, and contractors for any and all injuries and/or losses, including theft, loss of property, or death that I may sustain while participating in the BEATS, Inc program.

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MEDICAL HISTORY

BIRTH AND DEVELOPMENT

Pregnancy	Full Term	☐	Premature	☐	If premature, how many weeks?		
Delivery	Normal	☐	Cesarean	☐	Forceps	☐	Other

MEDICATIONS

Name	Dosage	Frequency	Reason

SURGERIES AND PROCEDURES

Surgery	Date	Doctor

Is there a history of seizures?	No	☐	Yes	☐	If yes, explain.		
Down Syndrome: Negative x-ray for atlantoaxial instability?	No	☐	Yes	☐	Date of x-ray		

PREVIOUS TESTING

	Test	Date Tested	Result
	Hearing		
	Psychological		
	Vision		
	Swallow Study		
	(Other)		

SERVICES CURRENTLY RECEIVING

Service	Frequency	Therapist/Practice

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MEDICAL HISTORY

Condition	Yes	No	Condition	Yes	No
Abnormal Fatigue	☐	☐	History of skin breakdown (If yes, please explain.)	☐	☐
Acute Arthritis	☐	☐			
Acute Herniated Disk	☐	☐	Hydrocephalus	☐	☐
Agitation with severe confusion	☐	☐	Implanted Devices	☐	☐
Allergies dust, mold, hay, etc	☐	☐	Incontinence	☐	☐
Aneurysm	☐	☐	Loss of sensation	☐	☐
Arnold Chiari Malformation	☐	☐	Multiple Sclerosis, acute	☐	☐
Asthma	☐	☐	Open wounds	☐	☐
Audible Aspiration	☐	☐	Osteogenesis Imperfecta	☐	☐
Cardiac/Heart condition	☐	☐	Osteoporosis	☐	☐
Circulation problems	☐	☐	Obesity Problems	☐	☐
Complete quadriplegia	☐	☐	Recent Dorsal Rhizotomy	☐	☐
Degeneration of hip joint	☐	☐	Scoliosis greater than 30 degrees	☐	☐
Diabetes	☐	☐	Seizure disorder	☐	☐
Excessive swayback/hunchback	☐	☐	Shunt(s)	☐	☐
Feeding Tube	☐	☐	Spinal fusion	☐	☐
Food Allergies (If yes, to what?)	☐	☐	Spondylolisthesis	☐	☐
			Silent Aspiration	☐	☐
Grafts over bony/weight bearing areas	☐	☐	Substance Abuse	☐	☐
Head injury	☐	☐	Tethered Cord	☐	☐
Hearing problems	☐	☐	Tracheostomy	☐	☐
Hemophilia/Blood disorder	☐	☐	Unstable neck or spine	☐	☐
Heterotrophic Ossification	☐	☐	Vision problems	☐	☐
Hip dislocation, subluxation, or dysplapsia	☐	☐	Other	☐	☐

GOALS/EXPECTATIONS

What do you hope to achieve through our services? What goals would you like to see accomplished?

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MOBILITY			
Child is able to:	**No**	**Yes**	**Yes, inconsistently or with modifications** (explain)
Roll on floor	☐	☐	
Transition to sit	☐	☐	
Sit unsupported floor	☐	☐	
Sit unsupported chair	☐	☐	
Transition to/from floor	☐	☐	
Crawl	☐	☐	
Kneel	☐	☐	
Cruise	☐	☐	
Stand >5 seconds	☐	☐	
Walk indoors	☐	☐	
Walk outdoors	☐	☐	
Walk up ramp/stairs	☐	☐	
Walk down ramp/stairs	☐	☐	
Run	☐	☐	
Step onto curb	☐	☐	
Step off curb	☐	☐	
Ascend stairs (reciprocally with no handrail)	☐	☐	
Descend stairs (reciprocally with no handrail)	☐	☐	
Get in/out of bed	☐	☐	
Get on/off chair	☐	☐	
Get on/off toilet	☐	☐	
Get in/out of car	☐	☐	
Adaptive equipment used:			
Mobility/gross motor concerns and further explanation of above:			

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ACTIVITIES OF DAILY LIVING

Child is able to:	**No**	**Yes**	**Yes, inconsistently or with modifications** (explain)
Eat using utensils	☐	☐	
Drink from cup	☐	☐	
Dress self	☐	☐	
Indicate need to toilet	☐	☐	
Use toilet	☐	☐	
Wash hands	☐	☐	
Bathe self	☐	☐	
Hold a pencil	☐	☐	
Knows letters	☐	☐	
Reads (level)	☐	☐	
Writes (level)	☐	☐	

Adaptive equipment used:

Activity of Daily Living skills/fine motor skill concerns and further explanation of above:

COMMUNICATION

Child is able to:	**No**	**Yes**	**Yes, inconsistently or with modifications** (explain)
Indicate yes/no (how)	☐	☐	
Communicate verbally	☐	☐	
Communicate other	☐	☐	
Receptive language	☐	☐	
Eat by mouth	☐	☐	
Express pain	☐	☐	
Play with peers	☐	☐	

Adaptive equipment used:

Communication concerns and further explanation of above: