Proven, playful intervention.

INTAKE PACKET

1410 Long Run Road
Louisville, Kentucky 40245
502.244.8011 p
502.244.6631 f

Dear Parent/Guardian:

Thank you for your interest in Green Hill Therapy!

Our goal is to help children reach their full potential through proven, playful intervention. Before we can begin the scheduling process, we require the following to be completed.

1. Physician's order that states the following:
   a. PT and/or OT to Evaluate and Treat (**do not specify hippotherapy or aquatherapy**)
   b. Your child's medical diagnosis, including ICD10 code
   c. Your child's date of birth
2. Provide legible copy of front and back of insurance card(s)
3. Completed Intake Packet

All three documents are required before we are able to schedule your child's evaluation or to add them to our wait list. If your child is also in a Kentucky waiver program (HCB, SCL or MPW, etc.), you must also complete and submit an EPSDT Enrollment Packet in addition to the Green Hill Intake Packet.

You may complete the GHT intake packet on your computer using Adobe software. Once completed, email, fax or mail back using the information below:

EMAIL:	courtney.springer@greenhilltherapy.org
FAX:	502.244.6631
MAIL or IN PERSON:	Courtney Springer Office & Billing Manager 1410 Long Run Rd Louisville, Ky 40245

Front office business hours are 8am to 5pm Monday through Thursday
Therapy hours are from 8am to 6pm Monday through Thursday

If you have any questions, please call us at 502.244.8011. We look forward to seeing you soon!

Sincerely,

LeeAnn Weinberg
Executive Director

Courtney Springer
Office Manager

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Patient Demographics

Please type or print clearly

Child's First Name ______ Child's Middle Name or Nickname ______ Child's Last Name ______

Address ______ Apt / Unit # ______

City ______ State ______ Zip ______

Date of Birth ____/____/____ Age ______ Male / Female Height ____ft____in Weight ____lbs

Ethnic Identity *(optional)*: Non-Hispanic or Latino Hispanic or Latino

Racial Identity *(optional)*: Caucasian African American Asian American Indian or Alaska Native

Native Hawaiian or other Pacific Islander

Name of School *(if applicable)* ______ Grade ______ Mainstream / Self-Contained

Services / Accommodations: OT PT ST Special Education

**Submitting a copy of your child's IEP encourages consistency and helps ensure Green Hill Therapy's efforts reinforce school goals.*

Mother's Full Name ______ Biological / Foster / Adoptive

Address *(if different from child's)* ______

Primary Phone Number ______ Email Address ______

Employer ______ Work Phone Number ______

Is an interpreter required: Yes / No Primary Language: ______

Father's Full Name ______ Biological / Foster / Adoptive

Address *(if different from child's)* ______

Primary Phone Number ______ Email Address ______

Employer ______ Work Phone Number ______

Is an interpreter required: Yes / No Primary Language: ____________________
Who does the child live with (provide names and relationships): ____________________

____

____

Custody arrangements, if any: ____

Alternate or Emergency Contact (outside the home):

____________________	____________________	____________________
Name	Phone Number	Relationship

How did you hear about Green Hill Therapy?

First Steps Physician Hospital Friend/Family Green Hill Staff Member / Client School Website / Social Media

Please provide name(s) if applicable: ______________________________

Insurance and Financial Responsibility Information

Please bring insurance cards to your first appointment

Primary

Aetna Anthem BCBS Medicaid Cigna EPSDT (for waiver programs) Humana Humana Caresourse Humana Military

Passport Self-Pay United WellCare Other:____________

____________________	____________________	____________________
Provider/ID #	Group #	Provider Services #
____________________	____________________	____________________
Subscriber Name	Subscriber DOB	Client Relationship to Subscriber

Plan reset date: ____________________ Does this plan have an Autism benefit? Yes / No

Secondary

Aetna Anthem BCBS Medicaid Cigna EPSDT (for waiver programs) Humana Humana Caresourse Humana Military

Passport Self-Pay United WellCare Other:____________

____________________	____________________	____________________
Provider/ID #	Group #	Provider Services #
____________________	____________________	____________________
Subscriber Name	Subscriber DOB	Client Relationship to Subscriber

Plan reset date *(if applicable)*: ____________________ Does this plan have an Autism benefit? Yes / No

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Financial Responsible Party

______________________________	________________	________________
Full Name	Date of Birth	Social Security Number
________________	________________	________________
Relationship to Child	Driver's License State & Number	Email Address
________________	________________	
Primary Phone Number	Secondary Phone Number	

Parent/Caregiver Questionnaire

Primary Concerns

Physical Therapy ____

____

____

Occupational Therapy ____

____

____

Primary Diagnosis

____

Secondary Diagnosis *(please list all)*

____

____

Is your child verbal? Yes / No Primary language spoken at home:__________________

Describe communication system used, if applicable *(sign language, device, pictures, etc.)*:______________

____

Does your child walk? Yes / No

Describe special equipment used *(walker, wheelchair, orthotics, etc.)*:________________________

____

Does your child receive behavior supports? Yes / No

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Describe any behavioral concerns *(self-injurious, tantrums, aggression, etc.)*:______________________________

____

____

Please provide the approximate age of when your child achieved the following milestones:

SKILL	AGE ACHIEVED
Said first word	
Sat up independently	
Crawled	
Walked	
Toilet trained	

Specialized Services History (i.e., PT, OT, ST, Behavior Supports, etc.)

Name of Facility	Type of Service	Name of Provider/Therapist	Treatment Frequency	Length of Treatment	Last Date of Service

Describe any adapted/specialized equipment or home programs: ______________________________

____

____

Your child's favorite toys and activities: ______________________________

____

____

Please tell us about your child on a personal level. What makes him/her laugh, sad, angry? How well does he/she follow directions? How does he/she react to sudden, loud noises or hearing another child scream or cry?

____

____

____

____

____

Functionality Rating Scale (FRS)

Scoring Instructions: Please indicate the level of instruction or ability for your child. Use Comments section to provide further details or explanations.

CATEGORY	ITEM	INSTRUCTIONS	COMMENTS
Self-Function	**Communication Ability**	3 = Normal 2 = Slightly delayed 1 = Markedly delayed 0 = Incomprehensible/none	
	Body Movement	3 = Normal movement 2 = Limited movement 1 = Severely limited movement 0 = No movement	
Self-Care Activities	**Feeding Assistance**	3 = Independent 2 = Minimal 1 = Partial 0 = Complete assistance	
	Toileting Assistance	3 = Independent 2 = Minimal 1 = Partial 0 = Complete assistance	
	Grooming/ Showering Assistance	3 = Independent 2 = Minimal 1 = Partial 0 = Complete assistance	
Dependence on Others	**Level of Functioning**	3 = Completely independent 2 = Independent in special environment 1 = Moderately dependent 0 = Totally dependent	
Social Adaptability	**Interaction with Others**	3 = Fully capable 2 = Situational limitations 1 = Extremely limited 0 = Unable to engage with others	
Medical Care	**Daily Medications**	3 = None 2 = 1-3 Medications 1 = 4-6 Medications 0 = > 6 Medications	
Total FRS Score:____________			

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Medical History

Prenatal

☐ Normal Pregnancy ☐ Complications: ____

Weeks Gestation: ____________________

Delivery

Presentation at birth: Normal / Breach Type of Delivery: Vaginal / C-Section

Anesthesia: Natural / Epidural / Spinal

Instruments used *(i.e., forceps, suction, etc.)*:____

Describe any complications with delivery:____

____

Birth Weight:_________lbs____oz Length:______________

NICU? Yes / No If yes, for diagnosis/treatment of:____

____

Length of NICU stay:______________________

Describe current feeding method: Self-feed Total-feed G-Tube

Describe any feeding or swallowing complications *(i.e., reflux, weight loss, failure to thrive, picky)*:____________

____

Did child pass last vision exam? Yes / No Glasses? Yes / No

Did child pass last hearing exam? Yes / No Hearing Aids? Yes / No

Does your child have a history of seizures? Yes / No Type:____________________________________

Frequency:_________________________ Precipitating Factors:____________________________________

Date of last seizure:_________________ Controlled by Medication:_________________________________

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Medical History

Describe any chronic conditions related to the following:

Neurological: ______________________________

____

Respiratory: ______________________________

____

Ear/Nose/Throat: ______________________________

____

Cardiac: ______________________________

____

Gastrointestinal: ______________________________

____

Orthopedic: ______________________________

____

Psychological: ______________________________

____

List all doctor's involved with the child's care at the present time:

	Name of Practice	Physician Name	Phone Number
Pediatrician			
Neurologist			
Pulmonologist			
ENT			
Cardiologist			
Gastroenterologist			
Orthopedist			
Psychologist/Psychiatrist			
Ophthalmologist			
Audiologist			
Other			

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Medical History

Hospitalizations/Surgeries

Procedure	Hospital/Doctor	Length of Stay	Date(s) or Age of Child

List of Current Medications

Medication Name	Dosage and Frequency

Allergies:____

____

Dietary Restrictions:____

____

Parental Waiver and Consent

Authorization and Acknowledgment

Initial: ______	By signing this waiver and consent, I, the legal parent/guardian, grant permission for my child, ______________________________________, to participate in the Green Hill Therapy program. I recognize and acknowledge the inherent risks of swimming, horseback riding, therapy and/or therapeutic activities. Because I acknowledge the risks associated with allowing my child to participate in the Green Hill Therapy program, I agree to release and hold harmless Green Hill Therapy, its founder, trustees, directors, officers, employees, agents, affiliates, volunteers and medical staff ("Staff") from any and all injury claims of any other nature which may result from my child's participation at and travel to or from Green Hill Therapy. I agree to indemnify and hold Green Hill Therapy, its Staff, and other children at Green Hill Therapy harmless from any and all liability caused by my child, whether or not intentional.
Initial: ______	I authorize Green Hill Therapy to release my demographic information to supporting affiliates who help with the cost of my child's therapy sessions.
Initial: ______	I authorize the release of information necessary to process insurance claims. I authorize my insurance benefits to be paid directly to the provider of service for services rendered as described. **I understand that I am responsible to pay all non-covered services/charges. I also understand that all co-payment and coinsurance amounts I am responsible for are due at the time service is rendered.**

ACCEPT	DECLINE	
		Evaluation/Treatment Consent: I give my permission for Green Hill Therapy to perform physical and/or occupational evaluation and therapy as deemed necessary by the clinician for my child. In the instance that any unusual problems occur, the parent/guardian will be immediately contacted as well as the child's Pediatrician. **I accept responsibility for the costs of all such evaluation and therapy treatment sessions that are not covered by insurance.**

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ACCEPT	DECLINE	
		Emergency Medical Consent: I understand parents/caregivers are required to remain on the Green Hill Therapy premises during the therapy session. I give my permission for Green Hill Therapy and its Staff to administer any medications needed and to provide and arrange for any necessary medical treatment to myself/my child while at Green Hill Therapy, including onsite and offsite emergency care. **I accept responsibility for the costs of all such medical treatment.**

ACCEPT	DECLINE	
		Photography Release: Without any further consideration from Green Hill Therapy, I hereby grant permission to Green Hill Therapy, its Staff and affiliates to utilize my child's appearance, performance, or voice in any and all manner and media throughout the world for the purpose of promotion, reporting or publication. Green Hill Therapy may use my child's name, likeness, voice and biographical material in connection with publication, promotion, exhibition and distribution of such material. I understand that no royalty, fee or any compensation of any kind shall become payable to me by reason of such release and use of any photograph.

Initial: ______	I have received a copy of the Notice of Privacy Practices. (A copy is also available in the Green Hill Therapy lobby and online at www.greenhilltherapy.org for your review.)

Please contact Green Hill Therapy at 502.244.8011 before signing if you have any questions.

I have read this form carefully and have had all questions answered before signing this legal document and giving the consents and waivers contained in it. I acknowledge that this is a legal document and I will be bound by my agreement to its terms. I represent to Green Hill Therapy that all information provided in this intake packet is accurate and complete and that I have the legal authority to provide consent on behalf of my child.

Signature represents legal authority for child listed above.

Print Name:	
Relationship to child:	
Signature:	**Date:**

Disclosures to Individuals Involved in Patient's Care

There may be times when it is necessary for an individual directly involved in your child's care to call the facility to inquire about his/her personal information or billing information. Please take a few moments to complete this form.

I authorize Green Hill Therapy to disclose my child's health information that is directly related to his/her current treatment to the individual(s) listed below for the purposes of their role in my child's treatment or payment for health services that my child has received.

Such persons involved in your child's care may include blood relatives, roommates, boyfriends or girlfriends, neighbors, teachers, caregivers, colleagues and etc.

Name	Relationship

I **do not** wish to have my child's health information disclosed to the individuals below even though involved in my child's care.

Name	Relationship

Parent/Legal Guardian Name: ____

Parent/Legal Guardian Signature: ____

Date: _________________________

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Green Hill Therapy

Patient Policy Manual

Rev. 2.0

1410 Long Run Road
Louisville, KY 40245
502.244.8011

www.greenhilltherapy.org

In order to make our relationship as enjoyable and productive as possible, this manual contains mutually beneficial requirements, which are necessary to ensure that there are no misunderstandings between parties. Please read these pages carefully and feel free to discuss any questions that you may have with our Executive Director. We look forward to a helping your child reach his/her full potential through proven, playful intervention.

I. PROGRAM OVERVIEW

Green Hill Therapy was founded in Louisville, Kentucky, by Shirley M. Cochran, M.S.P.T., P.C.S., pediatric physical therapist. Shirley was a lifelong horsewoman and professional rider for more than 15 years. She was first exposed to hippotherapy in graduate school, learning how beneficial the gait and movement of a horse are to an impaired person's neuromuscular system. Her experiences led to an intense passion for combining the healing power of the horse with classic therapeutic principles. So in the spring of 2000, Shirley began Green Hill Therapy in her backyard with three children and she witnessed amazing results.

Green Hill has grown exponentially over the past 17 years and now provides thousands of life changing therapy sessions to children each year with the help of 80+ dedicated volunteers.

Mission

Green Hill Therapy strives to provide year-round physical and occupational therapy in combination with hippotherapy and aquatherapy to children with special needs, regardless of their inability to pay.

Our goal is simple: We want to help kids reach their full potential through proven, playful intervention.

Our Programs

Our hippotherapy program is operated out of a 10,000 square foot facility that encompasses both clinical treatment space and an indoor riding arena. Green Hill Therapy is the only Louisville based organization providing year-round hippotherapy to children with special needs.

Hippotherapy refers to the incorporation of equine movement by physical therapy, occupational therapy, or speech language pathology professionals in treatment. These professionals use evidence-based practice and clinical reasoning in the purposeful manipulation of equine movement to engage the sensorimotor and neuromotor systems to create functional change in their patient. Used with other neuromotor and sensorimotor techniques, hippotherapy is part of a patient's integrated plan of care.

Green Hill Therapy's licensed therapists also provide aquatherapy to pediatric clients at the state of the art Kay & Jim Morrissey Advanced Therapy Center at Home of the Innocents.

Aquatherapy refers to the use of water and water-induced resistance to improve physical functioning as a method in which to rehabilitate, or re-educate, the human body.

II. HIPPOTHERAPY CONSIDERATIONS

An initial evaluation in pediatric physical or occupational therapy does not indicate that a child is appropriate for hippotherapy, even if recommended or cleared by a physician. This particular treatment tool can have several contraindications and comes with several precautions. The determination of appropriateness of a child for hippotherapy is based on the expertise and professional judgment of the medical team.

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Safety is the ultimate priority of everyone involved in a hippotherapy session, including the client, therapist, volunteers, and horses. The duration of hippotherapy sessions are determined by a variety of influencing factors and are based on professional judgments. Any or all of the following reasons may indicate a shortened hippotherapy session or no hippotherapy session for your child on a given day (shortened hippotherapy sessions translate into a longer clinic-based treatment session):

- Temporary change in client's medical status/behavior
- Lame or injured horse
- Environmental factors such as temperature or humidity
- Inadequate number or shortage of properly trained volunteers
- Re-evaluation and/or standardized testing

The following may result in the need to discharge a patient from hippotherapy:

- Change in medical status indicating a contraindication or precaution to hippotherapy
- Any change in physical, emotional, or cognitive status where safety risks outweigh potential benefits from therapy
- All goals for therapy have been met and client has age-appropriate functionality based on professional judgment from therapist and/or objective tests and measures
- Client is no longer making progress towards his/her therapy goals based on professional judgment from therapist and/or objective tests and measures

III. FIREARMS, WEAPONS, TOBACCO, ALCOHOL & DRUGS

No individual shall bring a firearm, simulated firearm, destructive device, deadly weapon or ammunition on Green Hill Therapy premises. The use of alcohol, tobacco, drug or any controlled substance is prohibited on Green Hill Therapy premises. These policies apply to both indoor and outdoor facilities, including parking lots, barns and fields.

IV. SUPERVISION

At least one parent/caregiver is required to remain on the premises during their child's session. Parents/caregivers are invited to shadow the therapy sessions as a means of encouraging continuity of care and improved outcomes for the child though please consult with your therapist first. When siblings are brought to the center, parents/caregivers must remain with them in the waiting area.

V. FINANCIAL RESPONSIBILITY

Before you begin treatment at Green Hill Therapy, we need you to understand the insurance (or other program) that will cover your child's medical care. We also need you to understand your financial responsibility for paying any unpaid portion of your bill.

We will work with you to help you understand your insurance to the best of our ability in order to avoid any financial surprises. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance (or other program) is accurate.

It is your responsibility alone to know what insurance or other plan your child is on, to supply us with the correct information at the time of each visit, and to know what services may or may not be covered. We encourage you to contact your insurance company with any questions you may have regarding the details of your coverage.

You are responsible for payment of all non-covered services at the time they are rendered.

VI. CLOTHING & ATTIRE

Children should arrive clean and fully dressed. Clothing should be comfortable and appropriate for horseback riding regardless of the time of year. Outdoor layers that are appropriate for the current weather and can be removed during the clinic-based portion of the session are strongly recommended.

Helmets are required while on horseback. Families are welcome to purchase an equestrian riding helmet for their child and bring it to each session. Personal helmets cannot be stored at Green Hill Therapy. Green Hill Therapy has helmets available for clients to utilize in the event that they do not have one of their own. Please be advised, these helmets are shared among many clients.

VII. ILLNESS

We operate a WELL CHILD facility. This policy will help protect all involved. A child ill with any of the following symptoms or behaviors shall not be admitted for therapy:

- Temperature of 100°F or higher; fever must be broken without medication for at least 24 hours before child returns to center
- Vomiting (any within 24 hours)
- Diarrhea (two or more loose bowel movements within 24 hours)
- Green mucus discharge from anywhere on body
- Excessive crying
- Fatigued/lethargic
- Lice
- Impetigo
- Strep Throat
- Scabies
- Rash of any kind
- Scarlet Fever
- Chicken Pox
- Ringworm
- Hepatitis A
- Croup

If your child develops any of the above symptoms while in our care, you will be required to leave immediately. Your child may return to care only after symptoms of the illness have disappeared. Please call to cancel your appointment as soon as possible if your child develops any of the above symptoms. If your child develops symptoms on the morning of your appointment, please notify Green Hill Therapy immediately. Unexpected illnesses that are not communicated in advance to Green Hill Therapy require a doctor's note for excusal. Otherwise, these absences count as a no show.

Should your child contract head lice and have attended Green Hill Therapy within 72 hours of diagnosis, we ask that you inform the Executive Director so that we can inform other parents to search for symptoms in their children and implement infection control procedures.

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VIII. ATTENDANCE

Regular, sustained, on-time attendance is key to your child making progress toward their goals. We reserve the right to discharge patients with a history of non-medical cancellations, excessive tardiness and no-shows. Patients with three no-shows and/or non-medical cancellations without 24 hours advance within in 6 month period *may* be discharged from Green Hill. Parents will be given a written warning via-email when their attendance violates policy to enforce attendance expectations.

IX. CLOSINGS

We reserve the right to close Green Hill Therapy early or for the day without notice in the event of unanticipated situations such as, but not limited to, power outages, no water, widespread illness and/or extreme weather conditions. Closures will be listed on our Facebook page (www.facebook.com/GreenHillTherapy) by 7:30 am. We also post closings on WHAS11 (www.whas11.com/closings).

X. CONCERNS AND COMPLAINTS

Please contact our Executive Director, Lee Ann Weinberg, at leeann.weinberg@greenhilltherapy.org with any concerns or complaints that arise while your child is attending Green Hill Therapy.

XI. REVISION TO MANUAL

Green Hill Therapy reserves the right to make changes to this Policy Manual as necessary.
Parents will be notified in writing of policy changes.

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Green Hill Therapy FAQ's

How long is a hippotherapy session?

Typically half of the session is 30 minutes of occupational or physical therapy in the clinic. The other 30 minutes is typically hippotherapy and performed in the arena.

What should my child wear?
Your child should dress in layers in all seasons and wear closed toe footwear. We provide helmets though you are welcome to purchase one for your child to bring to each session.

What is the cost of my session?
The cost is dependent upon your insurance plan. We accept Aetna (though out of network), Anthem, BCBS Medicaid, Cigna, Humana, Humana CareSource, Passport, Kentucky Medicaid (EPSDT), Tricare, UHC (though out of network) and Wellcare. The self-pay rate is $80. Co-insurance and/or co-payment is due at the time services are performed. We offer a special program through Kosair Charities for children who do not have insurance or are out of coverage. Inquire at the front desk for an application.

Can I leave while my child is in therapy?
Parents, guardians and caregivers are required to remain on premises throughout the duration of the therapy session.

Does therapy get canceled if it is extremely hot or cold?
Hippotherapy can be temperature dependent; however, we will still have occupational or physical therapy in the clinic regardless of outside temperature. Closures for other weather will be listed on our Facebook page www.facebook.com/GreenHillTherapy by 7:30 am. We also post closings on WHAS11 (www.what11.com/closings).

Can I watch or participate in the session?
Parents/caregivers are invited to shadow the therapy sessions in the clinic and arena as a means of encouraging continuity of care and improved outcomes for the child though please consult with your therapist first. When siblings are brought to the center, parents/caregivers must remain with them in the waiting area. You may watch and/or participate as a side walker in the hippotherapy session in the arena though please coordinate this with your child's therapist to ensure this is best for your child.

What are your hours?
Green Hill Therapy is open for clinic sessions and hippotherapy from 8:00 am to 6:00pm, Tuesday through Friday.

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XII. ACKNOWLEDGMENT OF EXPECTATIONS IN MANUAL

The Green Hill Therapy Policy Manual is the parent's ultimate guide when it comes to the rules and regulations associated with our program. By signing below, you are acknowledging that you have received and read the Green Hill Therapy Policy Manual and agree to abide by the principles outlined herein.

Child's Name: ____

Parent/Legal Guardian Name: ____

Signature: ____

Date: ____