green hill therapy
Proven, playful intervention.

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

INTAKE PACKET

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. Request a 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. Return the order and insurance card to Green Hill Therapy, so that we can schedule an evaluation

Prior to your child's scheduled evaluation, this intake packet must also be filled out completely. We strongly encourage you to return it to your office prior to your scheduled examination. If you are unable to return the packet to our office in advance for any reason, you must arrive at least 30 minutes prior to your scheduled appointment to complete the paperwork in our waiting room to allow time for your child's therapist to review the information. If you arrive without completed paperwork less than 30 minutes prior to your child's scheduled evaluation, your appointment may be cancelled and you will need to request your evaluation for another time after your competed paperwork has been received.

This form can be completed on your computer using free Adobe software. Once completed, email, fax or mail back using the information below:

EMAIL:	Sarah.Halfacre@GreenHillTherapy.org
FAX:	502.244.6631
MAIL or IN PERSON:	Green Hill Therapy 1410 Long Run Rd. Louisville, KY 40245

Hours of Operation are 8am to 6pm Monday through Friday

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

Sincerely,

Sarah J. Halfacre, MSOT, OTR/L, ATRIC, HPCS
Executive Director

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

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

Anthem BCBS Medicaid EPSDT Humana Humana Caresourse Passport 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

Anthem BCBS Medicaid EPSDT Humana Humana Caresourse Passport 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

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 Diagnosis

_____

Secondary Diagnosis *(please list all)*

_____

_____

Primary Concerns

Physical Therapy _____

_____

_____

Occupational Therapy _____

_____

_____

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

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

_____ _____ Mainstream / Self-Contained

Name of School *(if applicable)* Grade

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.*

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?

_____

_____

_____

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:_____

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			

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:_____

_____

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:_____			

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.**

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: _____

COVID-19 Virus
Preventative Measures

Patient Name: _____ Patient D.O.B.: _____ Patient Temp: _____

Green Hill Therapy is dedicated to providing quality therapy services to our patients and their families. We will operate following specific guidelines outlined by Governor Beshear and his team. We will continue to monitor the status of the novel COVID-19 virus and follow the Center for Disease Control infection control recommendations; this includes, daily temperature checks of staff and patients, adherence to social distancing, stringent sanitation measures, frequent handwashing, enhanced personal protective equipment, and providing easily accessible hand sanitizer and PPE for staff, patients and caregivers.

Despite these efforts, it is impossible to guarantee a virus free environment.
Populations such as individuals with pre-existing health conditions or compromised immune systems are at a higher risk of contracting the virus. If your child or any immediate family member fall within the high-risk category, we encourage you to reach out to your physician for additional recommendations.

COVID-19 affects different people in different ways. Infected people have had a wide range of symptoms reported – from mild symptoms to severe illness. If you, your child or anyone in your household are currently or have experienced the following in the past 14 days please refrain from attending GHT:

Symptoms that may appear 2-14 days after exposure to the virus:
Cough
Shortness of breath or difficulty breathing
Or at least two of the following:
Fever or chills
Repeated shaking with chills
Muscle pain
Headache
Sore throat
New loss of taste or smell
Congestion or runny nose
Nausea, vomiting, or diarrhea

We ask that you contact Green Hill Therapy to cancel your child's appointment as soon as possible. Your child's therapy services may resume once the household is symptom free for at least 14 days.

Thank you for continuing to entrust your child's therapy needs with us. If you have any questions or concerns please feel free to reach out to Green Hill Therapy at (502)244-8011 or sarah.halfacre@greenhilltherapy.org and, as always, speak with your child's physician for any medical questions or guidance.

Parent Name: _____

Parent Signature: _____

Date: _____

Child's Name: _____ Date of Birth: _____

1. I understand that my health care provider wishes me to engage in a tele-health intervention with the understanding that potential benefits include:
   1.1. By promoting caregiver-child interactions, caregivers become more aware of therapeutic opportunities during daily routines
   1.2. By observing care-giver/child/ environmental interactions, the therapist can develop treatment plans and home programs better tailored to their home environment
   1.3. Provides opportunities for intervention in lieu of cancelled in-clinic appointments
2. My health care provider has explained to me how the video conferencing technology will be used and intervention will not be the same as a direct patient/health care provider treatment session.
3. I understand there are potential risks to this technology, including interruptions, technical difficulties and a slight risk of security breaches. My healthcare provider will activate the video conferencing platform's security options and these measures will be explained to me prior to starting the first treatment session. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Other Green Hill Therapy health care providers may be present during the intervention other than my health care provider in order to operate the video equipment or assist with treatment demonstration. The above mentioned people will maintain confidentiality of the all information obtained. I further understand that I will be informed of their presence in the treatment session and thus will have the right to request the following: (1) omit specific details of my child's medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine room: and or (3) terminate the intervention at any time.
5. I have had the alternatives to a telemedicine intervention explained to me, and choose to participate in telemedicine intervention with Green Hill Therapy.
6. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfactions.

- If I cannot return this form via email with e-signature, I have agreed to returned the signed form via a method I choose (suggested: email using scanner/ fax (502) 244-6631/ USPS mail)

_____ _____

Patient's/parent/guardian signature Date

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.

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.

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.

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.

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: _____