2020 Information for Pediatrics In Motion Direct Treatment Clients at the Partners For Progress Therapeutic Riding Center

Clients that are in direct treatment with a therapist will receive Statements from Pediatrics In Motion (PIM) for those services. PIM will inform you if insurance will cover the treatments and bill the insurance company directly for you if coverage is available. See the PIM Policies page for further information regarding payment responsibilities.

Partners For Progress (PFP) provides the horses that are used by the PIM therapists during treatment. In order to provide the quality of horses that are used for treatment, PFP depends on the generosity and hard work of many volunteers, clients, and donors through direct donations and fundraising to keep the costs associated with these quality horses as low as possible for the client/rider families.

Participation in a Fundraising Option designated on the Partners For Progress Client Information Form, included with these PIM forms, is required of all families. Clients are always encouraged to participate in all PFP fundraising events that occur throughout the calendar year, however, there are two major fundraising events that are specifically designated to the Fundraising Option requirement.

The first event is PFPs' Plop O'Gold Annual Open House & Chili Cook-Off Raffle Fundraising event. This event is scheduled for Sunday, March 8, 2020. For this event, the fundraising requirement is to sell raffle tickets to raise money for the Horse Care Fund. The second event is PFPs' Denim & Diamond's Hoe Down Fundraising Gala. This event is scheduled for Saturday, September 12, 2020. For this event, the fundraising requirement is to assist with acquiring/donating the items necessary for the events' auction and raffle items.

Initial Fees:

1. $200.00 Evaluation Fee is payable to Pediatrics In Motion at the time of the **initial evaluation** by therapist
2. $50.00 Annual Registration Fee is required for each rider at the time of the first Treatment and annually every year thereafter on January 1st. ***NOTE: this fee is billed by, and payable to, Partners for Progress to offset insurance costs for the riders.)***

See the Pediatrics In Motion Policies page for further information regarding payments.

Paperwork: The following paperwork **MUST** be completed and returned to PIM prior to, or on, the clients' first day of treatment:

1. PIM Billing Contact Sheet
2. PIM Credit Card Authorization Form
3. PFP Client Information Sheet
4. PFP Participants Release Form
5. PIM Medical History (PIM understands that connecting with medical providers takes time, however, the Physician's Statement Form ***must*** be completed within 30 days of the clients' first day of treatment. The Rider's Medical History can be submitted prior to having the physicians' signature.)

2020 Pediatrics In Motion Policies

Revised - July, 2019

1. DEDUCTIBLES and CO-PAYS are due the month they are incurred. Please check with your provider for explanation of these items. **If your deductibles and co-pays are not paid in a timely manner, co-pays will be due at the time of treatment.**

2. Statements will be sent out around the 1st of every month via email unless stated otherwise and are DUE UPON RECEIPT. You may choose to have your statement automatically billed to your credit card by selecting the appropriate box on the PIM Credit Card Authorization Form.

3. After 30 days of no payment activity, a $20.00 Re-Bill Fee will be incurred for each month that a payment has not been received.

4. Secondary insurance is the patients' responsibility but PIM is more than willing to help in any way PIM can. After 6 months without payment from secondary insurance, the balance due is the patient's responsibility.

5. Once insurance has hit maximum benefits paid, the patient is responsible for full amount due.

6. Patients are required to fill out an updated contact sheet with a front and back copy of their insurance card yearly regardless of start date. They are also responsible for submitting any changes in insurance promptly.

7. Patient/Parent is responsible for getting and keeping script for services current.

8. PIM has a 24 hour cancellation policy.
    a. LATE CANCELS will be charged $50.00.
    b. NO SHOWS will be charged $100.00.
    c. EXTENDED ABSENCES of more than 2 in a row will incur a $25.00 per week appointment holding fee for the client.

9. Please understand that the client treatment is a partnership with the availability of volunteers from Partners For Progress. It is very difficult to schedule make-up treatments for clients due to the treatment schedules and time commitments of the therapists and volunteers. Please contact Amanda at 262-206-1567 to discuss scheduling a make-up. If a cancellation occurs due to Partners For Progress or Pediatrics In Motion, make-up times will be made available.

As a healthcare provider, **Pediatrics In Motion has a relationship with you**, not your insurance company. **All charges are your responsibility** as of the date that treatment is rendered if your insurance company does not pay PIM. PIM will, however, work with you to provide you with all the documentation necessary for reimbursement.

2020 Partners For Progress Facility Rules and Regulations

For your information and safety, below are the facility guidelines and rules from Partners For Progress. Thank you for your cooperation.

1. **Observation of Therapy:** We are happy to have family and friends of clients observe treatment sessions as long as it does not distract the client rider. In order to keep the integrity of the treatment session, we ask that you do not interrupt. Spacious viewing areas are provided; **please remain in these areas during each treatment session unless otherwise discussed and approved prior to treatment session.**
2. **Supervision of Children:** Children are welcome to come to the treatment sessions, but please keep them with you at all times. Due to safety factors they must be with an adult and remain reasonably quiet at all times. A child running or jumping or screaming or throwing a ball in the viewing area can spook a therapy horse as the viewing area glass is not mirrored on the inside.
3. **Pets:** Due to our commitment to the safety of our clients and horses, **no pets** are allowed on the premises. Service animals require submittal of a copy of their certification.
4. **Parking:** Park in areas designated only for parking. Drop off directly in front of the entry doors of the viewing area is reserved for non-ambulatory clients. Thank you.
5. **Alcohol/Smoking:** Absolutely no smoking or drinking is allowed on the grounds, or within this facility during treatment sessions.
6. **Entering and leaving the barn property:** For the safety of all, we ask that you enter and leave keeping your speed limit at 5 mph.
7. **All riders should wear:**
   - Long pants with comfortable fit to cover legs (weather permitting)
   - Shoes or boots
   - No loose or hanging clothing, rings, necklaces or dangle earrings
   - Independent riders must have their own riding shoes with heels (see your instructor for more information)

2020 Pediatrics In Motion Billing Contact Form

Patient Name _____ DOB _____

Parents/Guardian Name _____

Address, City, State, Zip _____

Phone: Home _____ Work/Cell _____

Who should PIM contact with billing questions? _____

Email address _____ to be used for correspondence and sending of Billing Statement. If you need your monthly Billing Statement to be mailed via USPS, please check this box □.

Primary Physician _____ Referring Physician _____

Phone _____ Phone _____

Insurer _____ Type (PPO, HMO, Other) _____

Insurance Plan Name _____

Subscriber Name _____ Subscriber DOB _____

Ins Member # _____ Group Number _____

Contact Number for Insurance _____ Relation to Patient _____

Deductible Amt $_____ Co-Insurance Amt $_____ Co-Pay Amt $_____

Number of Visits Allowed per Calendar Year: PT _____ OT _____ SLP _____

Other Therapy Services Rendered-Weekly or Monthly: _____

Familys' Primary Objective for Seeking Therapy _____

_____

The information provided above is both true and accurate to the best of my knowledge. I have submitted the required information on behalf of my child or myself and will keep **Pediatrics In Motion** updated of any changes that may occur with our personal information (address, phone, etc.), as well as insurance information.

I authorize the release of any medial information necessary to process this claim. I request that payment from my insurance company be made directly to **Pediatrics In Motion.**

Patient's Name _____ Date _____

Parents/Guardian Name _____

Signature _____ Date _____

2020 Pediatrics In Motion Credit Card Authorization Form

I clearly understand and agree that all services rendered to me and/or my child are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my/and or my childs' care and treatment, any fees for professional services rendered to me will be immediately due and payable. If there is any unpaid balance 60 days from my last visit, it will be charged directly to my credit card.

Authorization of Debit to a Credit and/or Debit Card:

Circle One: Type: Visa / MasterCard / Discover / AmeEx Is this a FSA or HAS card? YES NO

Card #: _____

Expiration Date: _____ Security Code: _____

Billing Address associated with Card listed above(Required):

Name on Card: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

I have read and understand the above statements.

Signature: _____

As a courtesy, if you would like to enjoy the added convenience of automatic billing to your card, please also check the appropriate box below and sign again.

☐ Please bill all of my regular charges to my card listed above after my monthly Billing Statement has been sent to me. I have read and understand the above.

Signature: _____ Date: _____

Thank you for your efforts and cooperation in the payment of your account.

As always, Pediatrics In Motion understands the difficult demands of our clients and is sensitive to payment arrangements. It is the client's responsibility to contact Pediatrics In Motion to arrange a suitable payment schedule.

2020 Partners For Progress Client Information Form Sheets

Client Name/Address:

Client First Name: _____ **Last Name:** _____

Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

FON: Main_____ **Alternate:**_____

County: _____ **Year Born:** _____

Ethnicity: ____ Caucasian ____ Middle Eastern

____ African American / Black ____ Pacific Islander

____ Hispanic / Latino ____ Native American / Alaskan

____ Asian ____ Other: _____

Parent / Guardian Contact Information:

If Client is under 18 or has a guardian enter information below.
Address is only needed if different from client address.

First Name: _____ **Last Name:** _____

Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Employer Name: _____

Employer City: _____

Second Parent / Guardian Contact Information:

If Client is under 18 or has a guardian enter information below.
Address is only needed if different from client address.

First Name: _____ **Last Name:** _____

Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Employer Name: _____

Employer City: _____

Emergency Contact Information:

Emergency Contact Name: _____

Relationship to Client: _____

Emergency Contact Phone: _____

Secondary Emergency Contact Name: _____

Relationship to Client: _____

Secondary Emergency Contact Phone: _____

Photo Release:

I authorize the use and reproduction by Partners for Progress NFP and/or Pediatrics in Motion of any photographs and any other audio-visual materials taken of me or my child for promotional materials, education activities, exhibits, or for any other use for the benefit of the program.

_____ **I consent** _____ **I do NOT consent**

Signature _____

Pediatrics in Motion

Fundraising Options:

You MUST choose an option below. If an option is NOT chosen, it will be assumed that the client is NOT participating in Fundraising and the $25.00 Horse Usage Fee per treatment session will be applied to client billing.

_____ I agree to participate in the PFP Fundraising by selling/buying raffle tickets for the Plop O'Gold event to raise at least $400 and contributing to the Hoe Down event by assisting with the acquiring/donating of items necessary for the events' auction and raffle items.

_____ I choose not to participate in the fundraising events and understand that I will be charged a $25.00 Horse Usage Fee per treatment session, which is an additional cost to my co-pay/co-insurance costs.

Billing Information:

Invoices for the Horse Usage Fee are emailed two weeks prior to each session.
Please provide the billing contact information below:

Name of Contact for Billing: _____

Email Address: _____

Please provide your credit card information below. For your convenience, PFP will automatically charge your credit card when treatment session fees are due. An additional charge of 2.5% will be added to each charge to cover credit card processing fees. (i.e., charge of $6.25 will be applied for a $250.00 invoice).

_____ I would like my credit card charged automatically when treatment session invoices are due.

Credit Card Information:

Name on Card: _____

Account Number: _____

Expiration Date: _____ Security Code: _____

eMail to notify of charge: _____

2020 Participants Release and Hold Harmless Agreement

Client Name: (Print) _____

THIS RELEASE LIMITS OUR LIABILITY. READ IT!

By signing this form, I acknowledge that therapeutic and pleasure horse riding is a dangerous activity, which may result in injury to my horse, or me or result in damage to my equipment. With this knowledge, in consideration for the services of Partners For Progress NFP and Pediatrics In Motion and as inducement for the services of Partners For Progress NFP and Pediatrics In Motion to provide therapeutic pleasure horse riding and/or physical therapy on horseback to me, I hereby waive, release, discharge and hold harmless Partners For Progress NFP and Pediatrics In Motion, its officers, directors, employees and volunteer assistants, their heirs, executives, administrators, successors or assigns, from any and all liability for damages sustained by me, any animal owned or controlled by me, or for any item or personally under my dominion and control. Without limiting the generality of the above, I hereby waive and release Partners For Progress NFP and Pediatrics in Motion, its officers and directors and all volunteer assistants for liability based on the active or passive negligence of said persons and entities.

I hereby agree to indemnify and hold harmless Partners For Progress NFP and Pediatrics In Motion, its officers, directors, and all volunteer assistants associated therewith for any claims which may be made against them, including attorney's fees and cost of suit in any action based upon or arising from my acts or omissions, or the actions of any animal with my control.

WARNING: Under the Equine Activity Liability Act, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risk of equine activities.

I acknowledge that I have read the foregoing and understand that contents thereof.

_____	_____	_____
Client Name (Please Print)	Signature	Date

If client is a Minor:

Minors must have the following signed by their parents or legal guardian:

I, the undersigned **parent or legal guardian** named here _____ of the client named here _____ for and in consideration of our child's participation at Partners For Progress and Pediatrics In Motion state that I have read the waiver, release and hold harmless written above, and I expressly agree that warrant I have health and accident insurance for said minor.

Signature_____ Date_____

Pediatrics in Motion

2020 Client Riders' Medical History and Physicians' Statement

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of Parent/Guardian: _____

Diagnosis: _____ Date of Onset: _____

** For Persons with Down Syndrome

- Cervical X-ray for Atlantoaxial Instability: Positive____ Negative____ X-Ray Date: _____

Tetanus Shot: Yes___ No___ Date: _____ Height: _____ Weight: _____
Seizure Type: _____ Controlled: _____ Date of Last Seizure: _____
Medications: _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			
Other			

Mobility:

Independent Ambulation: Yes____ No ____
Crutches: Yes____ No ____
Braces: Yes____ No ____
Wheelchair: Yes____ No ____
Please indicate any special precautions: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Partners For Progress NFP and/or Pediatrics In Motion will weigh the above medical information against the existing precautions and contradictions.

I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Name (Please Print) _____ Physician's Signature _____ Date _____

2020

Partners For Progress, NFP

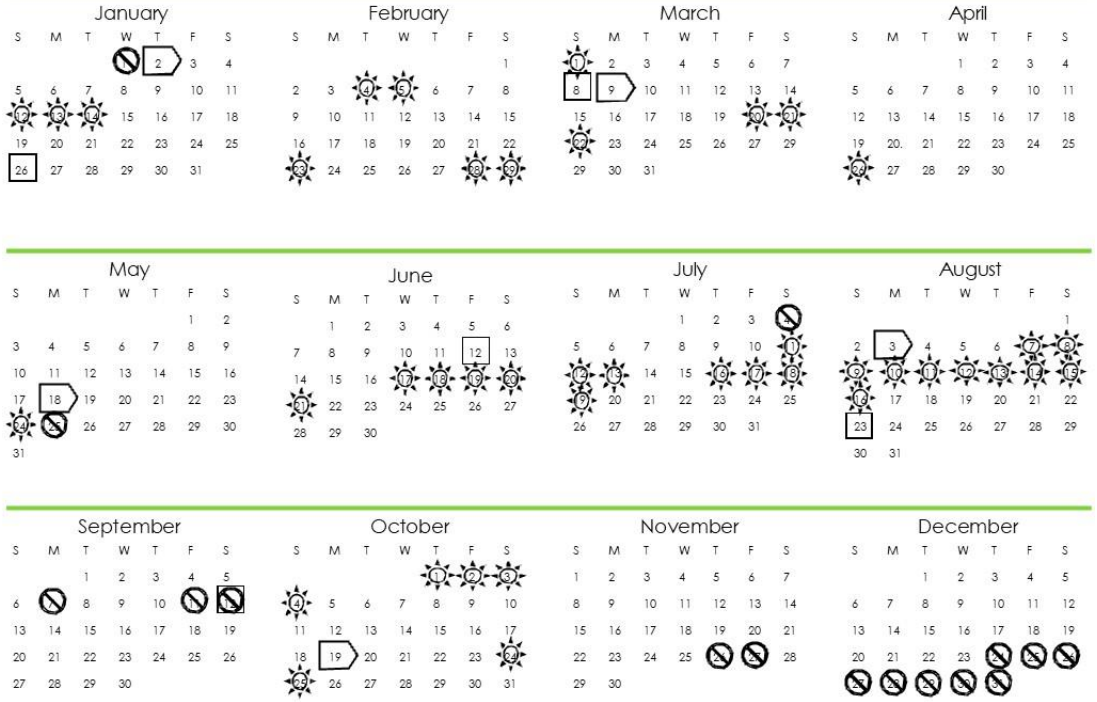
challenging therapy that's changing lives…..

Schedule of Events

- **SESSIONS**
  - **1:** January 2 - March 7
  - **2:** March 9 - May 16
  - **3:** May 18 - August 1
  - **4:** August 3 - October 17
  - **5:** October 19 - December 23
- **EVENTS**

January 26	**- Meat Raffle**
March 8	- Plop O'Gold & Chili Cook-Off Open House
June 12	- Dance Bash
August 23	- Familyfest
August	**- NSBA World Show**
September 12	- Hoe Down Gala
October	**- All American Quarter Horse Congress**
October	- Special Olympics

- **KEY**
  - - Start of Session
  - - Event
  - - No Riding
  - - Show Team Horse Shows



MAILING ADDRESS:

Partners For Progress, NFP
23525 W. Milton Road
Wauconda, IL 60084

FACILITY LOCATION:

PFP Therapeutic Riding Center
23525 W. Milton Road
Wauconda, IL 60084

Fon: 847-438-5400
Web: www.partnersforprogressnfp.org
Email: info@partnersforprogressnfp.org
FB: Partners For Progress NFP Therapeutic Equestrian Center

Mailing Address & Location: 23525 W. Milton Road - Wauconda, IL 60084
Phone: 847.438.5400 • Website: www.partnersforprogressnfp.org • Tax ID # 20-2375514

Challenging & effective therapy that's changing lives

Pediatrics in Motion