EQUINE CONSENT FOR MEDICAL TREATMENT

Owner/Horse Name:_____
Home Address:_____
_____
Home Phone:(_____)_____ Cell #(_____)_____
Emergency Contact:_____; Phone (_____)_____
Email:_____; Referral Source:_____

CONSENT TO TREATMENT: I hereby consent to the administration of Physical Therapy/Massage Therapy/Pilates services as directed Leah Darling, PLC. This may include manual therapy, therapeutic exercise, and neuromuscular reeducation. I understand the therapist or I may discontinue the session at any time. I realize treatment is being given for the well-being of my horse's body. This includes increased circulation, joint flexibility and range of motion as well as reduce stress, anxiety, muscle stiffness, tension and pain. This therapy is NOT as substitute a veterinarian. The therapist cannot diagnose disorders, prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations.

RELEASE OF RECORDS: I authorize the release of medical records information to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I also understand my records may be related to state, federal, or other surveyors for accreditation and/or regulatory licensing purposes. I authorize the release of medical record information to the physician(s)/agency responsible for my care. I also authorize release of my medical record information as required by law.

CANCELLATION POLICY: Cancellation of appointments less than 24 hours in advance will be ***charged in full***. Medical Records preparation charge $25.00 per request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care from Leah Darling, PLC.
Please circle one re: Notice of Privacy Practices:

I have received a copy/// I have previously received a copy/// I do not want a copy.

FINANCIAL AGREEMENT: I give consent to Leah Darling, PLC for the administration of Physical Therapy. I understand that I am responsible for my bill. I understand that I, the client am responsible for verifying insurance coverage, filing for authorization, submitting records for reimbursement if desired. Payment is due at time of services provided. Payment records and clinical records will be provided on request so that individuals may file for reimbursement if desired. Leah Darling, PLC is NOT a Medicare provider, will not provide Medicare Opt out, and does not accept insurance assignment.

Owner's Signature:_____**Date/Time:**_____