



### **1. Assignment of Benefit Release**

I hereby agree to treatment and release of payment by my insurance plan to Equine Therapy of NJ, LLC for services rendered. I understand that I am financially responsible to Equine Therapy of NJ, LLC for charges which are not covered by my benefit plan. <sup>1</sup>

DATE \_\_\_\_\_ SIGNATURE OF PATIENT \_\_\_\_\_

### **2. Missed Appointment Fee**

I hereby acknowledge the 24-Hour Cancellation Fee as follows: you must notify the office within 24 hours if you have an appointment you are unable to keep. The missed appointment fee will be \$25 for each appointment that is missed without 24 hours' notice given. If you miss 2 consecutive appointments, we cannot guarantee your standing appointment time will be held for you.

DATE \_\_\_\_\_ SIGNATURE OF PATIENT \_\_\_\_\_

### **3. Notice of Privacy Practices**

I hereby acknowledge that I have read a copy of the Notice of Privacy Practices. If I request a written copy of this notice, then I will be given one. I understand that if I have any questions regarding this Notice or my privacy rights, I can contact Equine Therapy of NJ, LLC at 201-919-6180.

DATE \_\_\_\_\_ SIGNATURE OF PATIENT \_\_\_\_\_

### **4. Authorization for Electronic Communication**

I agree that Equine Therapy of NJ, LLC may communicate with me electronically unless and until I revoke this authorization by submitting notice to them in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties. I hereby authorize the transmission of my protected health information electronically as described above.

DATE \_\_\_\_\_ SIGNATURE OF PATIENT \_\_\_\_\_

### **5. Waiver and liability release**

As a consideration for Equine Therapy of NJ, LLC allowing the client to engage in the activities as any time and at any location, the client and/or the parent/guardian on behalf of the client assumes full responsibility for any and all bodily injuries, losses or damages that may be sustained pursuant with NJ Law P.I., Chapter 287. The client and/or the parent/guardian on behalf of the client, for any and all heirs, administrators, personal representatives, or assignees, release and discharge Equine Therapy of NJ, LLC and its employees, assistants, directors, volunteers, land owners and owners of horses from any and all claims, demands, damages, actions, omissions, suits, or causes of action.

DATE \_\_\_\_\_ SIGNATURE OF PATIENT \_\_\_\_\_

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