Horses Adaptive Riding & Therapy

'Harnessing the magic of horses to change lives'

Welcome Letter

Dear New Client and Family,

Thank you for choosing Horses Adaptive Riding and Therapy and welcome to the HART family! Our nonprofit organization was created to provide safe and satisfying equine-assisted therapy to adults and children in the Mid-Willamette Valley. These services are provided in a nurturing and wholesome environment where the needs of our clients come first.

HART's staff and volunteers create rewarding relationships with each special needs client in our programs. Our compassionate and knowledgeable staff are each uniquely qualified to offer a variety of equine-assisted therapies.

It can be confusing to know which equine therapy program to sign up for and our staff will help guide you in that choice.

Adaptive Riding sessions are led by professional instructors with a passion for seeing clients flourish. Riders can receive a number of physical and neurological benefits due to the rhythmic, repetitive motion of the horse's gait including balance, strength and flexibility.

Equine Assisted Learning sessions utilize natural horse and herd behavior to model human mental and emotional health and are led by certified EAL instructors.

Veterans are welcome and invited to participate in any of the above-mentioned programs. We are proud to offer these services to military personnel.

Equine therapies at HART are only possible due to the generosity of the community and our volunteers. Please get to know the volunteers and staff who work with you or your child and please spread the word about the wonderful work we do here!

We look forward to seeing you and/or your child soon.

Sincerely,

The Staff and Volunteers of HART

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Client Orientation Form

Carefully read, sign and return

- All clients or guardians are required to read and sign a liability waiver prior to participation
- Everyone in your party must sign an inherent risk waiver
- When you arrive, please drive slowly and watch out for farm equipment, animals and pedestrians
- Long pants and sturdy shoes recommended
- Children cannot participate without a parent or guardian present
- Safety is our utmost priority
- Volunteers are experienced and take direction from our therapists and instructors
- Our therapy horses are well trained, healthy and valued as a member of our team
- Only one client per horse
- This is a working stable, and although we maintain a warm and friendly environment, it is not appropriate to pet or feed the horses without consent
- An instructor/therapist will always be present during sessions
- We ask that you help us set individual goals in equine-assisted therapy
- The maximum weight limit for riding is 180 pounds, however, non-riding activities are available for those exceeding the weight limit
- Custom riding equipment is available for those who need it
- We prefer you to make a commitment of at least one session per week
- HART staff & volunteers will not discriminate on the basis of a client's race, religion, gender, sexual orientation, age, national origin, ancestry, economic status, or mental or physical disability.
- Each client must wear an A.S.T.M. approved equestrian helmet before mounting. If you don't have a helmet we will provide you with one.
- Siblings are welcome, but must remain under the direct supervision of a parent or guardian and not distract from the sessions
- Pets welcome with pre-approval, but must be on leash at all times! Please clean up after your pet
- Recreational use of drugs or alcohol is *not* allowed prior to, or during equestrian activities
- **Our fees:**
    - Adaptive Riding and Equine Assisted Learning is $35 per 30 minutes session. If you have a financial hardship, limited scholarships may be available

If you have any questions regarding these procedures, please discuss them with staff prior to the beginning of your session. Your participation signifies full acceptance of all rules and conditions.

_____ _____

Print full name of client Signature of client (or guardian)

Date _____

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Participant Application

To be completed by the participant or parent/legal guardian

Participant's Name: _____ Date: _____

DOB: _____ Age: ____ Height: ____ Weight: _____ M/F (circle one)

Veteran? Yes No (circle one)

Ethnicity *(Used for grant seeking purposes only)*

___ African American ___ Asian/ Pacific Islander ___ Caucasian ___ Hispanic ___ Native American ___ Other

Address: _____ City: _____ Zip: _____

Parent/Legal Guardian: _____

Home phone: _____Work phone: _____ Cell phone: _____

Please list preferred method of contact: _____

Email: _____

PLEASE ATTACH PHOTO HERE

Diagnosis: please list all _____

Therapist name and type: _____

Therapist phone number: _____

Please rate the following systems/areas:

*Use Good, Fair, or Poor and add details if needed

Vision: Hearing:

Sensation: Communication:

Heart: Breathing:

Circulation: Emotional:

Behavioral: Pain:

Bone/Joint: Muscular:

Thinking/Cognition: Allergies:

Seizures: Y_____N____ IF yes - date of last seizure_____

Other:

FUNCTION Describe participant's abilities/difficulties in the following areas, including assistance required or equipment needed: (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____

_____

_____

_____

Can participant sit without support? If not explain what support is needed?

_____

_____

Can participant transfer without assistance? (circle one) Yes No

What are the participant's various social interactions (i.e. Work/school including grade completed, leisure interests, relationship/family structure, support systems, companion animals, fears/concerns, etc.)**?**

_____

_____

_____

_____

What goals do you hope to be accomplished with participation?

_____

_____

_____

_____

Are there any significant behavioral issues, triggers or past incidents that may affect participation?

_____

_____

_____

_____

_____

Additional information that you'd like to share:

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Assumption of Risk and Release of Liability

On behalf of myself _____or_____ (minor), I recognize that horseback riding is an inherently dangerous activity that can result in injury or death.

I hereby assume all risk in connection with being on or around horses at Horses Adaptive Riding and Therapy's activity sites and agree to release, defend, hold harmless and indemnity Horses Adaptive Riding and Therapy, its officers, directors, employees, staff and agents, licensees and invitees from all claims, damages, liabilities of judgments (including costs and expenses incurred in connection therewith) arising from injury, death, or damages to any person or property whatsoever arising out of or in connection with me or my minor child's use and occupancy of the premises and its facilities, whether or not the death, injury or damage is caused in whole or in part, by the act, neglect, fault of, or omission of any duty by me or my minor child.

Under Oregon Law, ORS 30.687 to 30.697, and Equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities

Signature of Adult: _____

Printed Name: _____

Date: _____

Signed on behalf of the following minors_____, _____,

_____, _____

Photo Release

I consent to and authorize the use and reproduction by Horses Adaptive Riding and Therapy of any and all photographs, and any other audio-visual materials taken of me or my child for promotional material, educational activities, and exhibitions of for any other uses that benefit the program.

Date: _____

Signature of participant (if over 18): _____

Signature of Guardian: _____*(If under 18 years of age)*

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Emergency Medical & Treatment Authorization

[In the event emergency medical and or treatment is required the undersigned authorizes Horses Adaptive Riding and Therapy to secure and retain medical treatment and transportation] (*check one)*

___Participant ___Staff ___Volunteer

Name_____ DOB_____

Phone _____

Address _____

Physicians Name: _____ City_____

Health History:

__ Allergies *(please list)* _____

Consent Plan

The authorization includes medication, x-rays, surgery, hospitalization, and any treatment procedure considered 'life-threatening' by the attending physician. This provision will only be invoked if the person listed below is unable to be reached.

Emergency Contact: _____ Relationship_____

Home Phone: _____ Cell: _____ Work Phone_____

Date: _____ Consent Signature_____

(*Parent or guardian if participant is under 18 years of age)*

Non-Consent Plan

I do not give my consent for emergency medical treatment in the case of an injury or illness. In the event emergency treatment is required, I wish the following procedures to take place:

_____

_____

_____

Date: _____ Non-Consent Signature_____

(Parent or guardian if participant is under18 years of age)

Emergency Information

NAME: _____	**DATE OF BIRTH:** _____
EMERGENCY CONTACTS, NUMBERS AND RELATIONSHIP TO CLIENT: 1. _____ 2. _____ 3. _____	**MEDICAL HISTORY**:
PHYSICIAN:	**ALLERGIES/ASTHMA**?
HEALTH CARE PLAN(S):	**ALLERGIES TO MEDS**:

List of Current Medications

NAME OF MEDICATION	AMOUNT	HOW OFTEN?

Printed name of person completing form: _____ Date: _____

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SCHEDULING AND FEES

ADAPTIVE RIDING AND EQUINE ASSISTED LEARNING FEES

The fee for each 30-minute session is $35. **Payment is due at time of service.**

SCHEDULING

Your session schedule will be pre-confirmed with you in advance. **You must respond to the text** to avoid being charged for the session as a "No Show". Your appointment time is unlikely to change from week to week. You are welcome to ask for an appointment change and we will do our best to oblige. You will be responsible for the session fees if you don't show.

CANCELLATIONS

We understand that we serve an often-fragile population and will work with you on an individual basis. **If you or your child are sick you must call or text prior to the session in order to avoid being charged for a No-Show session.**

SCHOLARSHIPS

We are doing our best to keep the fees as low as possible. If your family has a low income and needs financial assistance to help pay for the sessions, there are partial scholarships available on a limited basis. ***You will always have co-pay***. If you need a scholarship, please talk to HART's Executive Director.

GIFT CERTIFICATES

Friends and family can help pay for sessions. They can purchase Gift certificates for sessions at info@horsesadaptiveriding.org. This is a great way for friends and family to help.

Signature: _____ Date: _____
Client (or Parent/Guardian)

Client Name: _____
Please print

Return completed form to:

HART
PO Box 121
Rickreall, OR 97371
Or you can scan and email to: info@horsesadaptiveriding.org

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Cancellation Policy

In order to keep our costs to clients affordable and in order to prevent asking for pre-paid sessions, we must adhere to a respectful cancellation policy.

Our Commitment to you:

- If the weather creates a dangerous situation at the barn we will cancel sessions and notify you as soon as the decision is made. If the Salem/Keizer School District is closed due to weather, HART will be closed. Keep an eye on HART's Facebook page for regular weather updates.
- COLD - We will hold sessions unless the mid-day temperature is 32f or below
- HEAT - We will hold session unless the mid-day temperature is above 95f - If the instructors feels it is too hot to ride, we will enjoy other horse activities (leading, bathing, grooming, etc.).
- UNSAFE CONDITIONS - We will notify you if we have an emergency at the barn and feel it is unsafe or if we feel there are unsafe road conditions. We will do our best to assess the safety of driving to the barn, based on the available weather reports as well as reports from people who live near the barn.

  Notifications:
- We will give you as much advanced notice as we can of any needed cancelation.
    - All clients and volunteers will receive a cancellation call/text/email as soon as the decision is made. Cancellations will also be posted to the HART Facebook page so be sure and check the page often.

Your Commitment to HART:

- I understand that HART has expenses even if I do not show up and that my co-pay is vital to providing services to the community.
- I also recognize and respect that many people have given up their personal time to volunteer so that I/my child can participate in equine assisted therapy and out of respect for them, I agree to give as much notice as possible when canceling my/my child's session.
- I further agree not to cancel my riding appointment with less than a 24-hour notice except in the case of sickness or an emergency.

If 24-hour notice is not given the following procedure will be followed:

- I will be contacted by staff to discuss the failure to attend my session. (The first no show or failure to attend will be forgiven and no payment will be required)
- If a second no-show or cancellation with less than 24 hour notice, I agree that I will personally pay for the session (In the case of third party billing such as insurance or other agency, the third party will NOT be billed and I will be the responsible party). I further agree to make this payment before my next session.
- If a third no show or late cancellation occurs the staff will contact me and depending on the individual circumstances, my appointment time may be given to someone on the waiting list.

Client Name_____ My Name _____

Signature (over 18 years of Age) _____ Date _____

HIPAA Privacy Authorization Form

the Oregon Board of Parole & Post-Prison Supervision

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

☐ I authorize the Board of Parole and Post-Prison Supervision to use and disclose the protected health information described below to _____ _____.

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record contained in the Board files (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Genetic testing information

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

**5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date

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Privacy Agreement

I understand that HART keeps a record of each client's disability, including any medical diagnoses and or medications and any other important considerations which the staff feels are necessary to adequately serve the participant. This allows the staff and volunteers to be informed of any specific safety considerations and to better develop emergency plans that are based on the participants medical needs.

HART staff and volunteers are trained on how to handle sensitive information.

For the purpose of funding and community relations, your success story may be used while protecting the true identity of the participant. Photos may be shared (but only with your permission) via the written photo release and whenever possible you will be asked to give verbal permission to use the photo.

Print Name of Participant_____ _____Signature of Participant:_____

Address_____City_____State_____Zip_____

(Complete this section if participant is under 18 years of age)

Parent or Guardian Indemnification

In consideration of _____'s participation in HART's activities, I agree to this privacy agreement on behalf of the above listed minor, and which are in any way connected with said minor's participation.

Print Guardian Name_____

Signature of Guardian_____

Date_____