Innovative Therapeutic Riding Program

Rider Application 2017

Mailing Address: P.O. Box 51571, Idaho Falls ID 83405
KayLynn 208-569-4809 or Val: 208-351-9463
Arena Located at: 7055 west 33rd South, Idaho Falls, ID 83402

PARICIPANT INFORMATION

(To be completed in full)

Name:_____

Today's Date:____/____/____DOB:____/____/_____

Gender:_____ Age:_____

Height: _____ft._____in. Weight:_____

Primary Phone:_____

Secondary:_____

Email:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Language Spoken:_____

Primary – Diagnosis _____

_____

Secondary – Diagnosis_____

_____

Ambulatory :_____

Have there been any seizures in the last year?

Yes___ No___ Most recent date:_____

Are they controlled? _____

Seizure Type_____

PARENTS/LEGAL GUARDIANS/CAREGIVER INFORMATION

Name: _____ Relation:_____

If different from Participant information, please fill out:

Address:_____

_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Email:_____

EMERGENCY CONTACT INFORMATION
(If different from above)

Name:_____
Relationship:_____
Primary Phone:_____
ALT Phone:_____

Allergies: List all known Allergies, Reactions, and Medications_____

_____

_____No Concerns

Medical History/Comments
Surgeries (include dates):_____
Medications: _____
Precautions: _____
Other Therapies (type and frequency) _____
_____

Family Information:
In group home/lives with parents, have siblings, ect: _____
_____
_____
_____

Name:_____ DOB:_____ Phone:_____

Address:_____

Physician's Name:_____ Preferred Medical Facility:_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name:_____ Relation: _____ Phone: _____

Name:_____ Relation: _____ Phone: _____

Name:_____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize **Innovative Therapeutic Riding Program** to:
(Center's Name)

1. Secure and retain medical treatment and transportation if needed
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be involved if the person(s) above is unable to be reached.

Date: _____ Consent Signature:_____
(Client, Parent or Legal Guardian)
Signed in presence of center staff

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

Date: _____ Consent Signature:_____
(Client, Parent or Legal Guardian)
Signed in presence of center staff

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM

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Liability – Hold Harmless – Assumption of Risk 2017

Please read carefully before signing

1. I, _____, the undersigned have read and understand and freely and voluntarily enter into this Release and Hold Harmless Agreement with Innovative Therapeutic Riding Program, LLC (hereinafter referred to as ITRP). I understand that this Release and Hold Harmless Agreement is a **Waiver of any and all Liabilities** that may be incurred by me as results of participating/volunteering with ITRP.
2. I understand that ITRP makes EVERY effort to maintain very high standards of safety in the following areas: Administration, Program and Facilities as determined by the governing agency for therapeutic riding centers, Professional Association of Therapeutic Horsemanship International (PATH Intl.) Nevertheless, I understand that accidents can occur and I agree to hold ITRP and Schaefer Livestock dba Box T Barn and Stables harmless in the event of such accident.
3. HELMET USE: I understand that under the PATH Intl. standards for safety, ALL Participants, volunteers, and personal (adults and minors) in any ITRP mounted or driving activity are required to, and in fact WILL wear, protective headgear that is American Society for Testing and Materials-Safety Equipment Institute (ASTM-SEI) approved for equestrian use. If helmets do not meet these standards, they will meet the **"PATH Intl. Guidelines for Alternative Helmet Use."** As a Participant/Volunteer, I agree to abide by this standard at all times.
4. I understand that myself or my minor child working with and around the horses of ITRP on Schaefer Livestock dba Box T Barn and Stables property as a client, staff member, or volunteer has inherent risks that have been minimized as much as possible by ITRP. Nevertheless, I understand that accidents can occur and I agree to hold ITRP harmless in the event of such accident.
5. I understand that potential dangers that I or my minor child could incur in being with, walking with, grooming, tacking, mounting, riding, dismounting, feeding horses, and using equipment around and with the horses, including but not limited to any interactions with other horses at the ITRP Facility. Understanding those risks for myself or my minor child, I hereby release ITRP and Schaefer Livestock dba Box T Barn and Stables from any liability whatsoever in the event of injury or damage of any nature or death to me, my child, or anyone else caused by or incidental to my electing to have myself or my child be involved with the horses and equipment of ITRP. This release of liability applies to ITRP, Schaefer Livestock dba Box T Barn and Stables, their officers, directors, trustees, agents, shareholders, instructors, therapists, staff, volunteers, representatives, successors, assigns, and anyone else directly or indirectly connected with ITRP or Schaefer Livestock dba Box T Barn and Stables.
6. I further voluntarily agree and warrant to Release and Hold Harmless all the above named organizations and people for any and all manner of claims demands and damages of every kind or nature whatsoever, which I may now, or in the future have against ITRP or Schaefer Livestock dba Box T Barn and Stables, and not limited to any incident caused by or related to negligence by the above named, including but not limited to injuries, death, or property damage from: being with, walking with, grooming, tacking, mounting, riding, dismounting, feeding horses; using equipment around and with the horses; and use of horse barn, Paddock, trails or arenas in any capacity.
7. WARNING: UNDER IDAHO LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITIES PURSUANT TO C.R.S

I, the undersigned, hereby intending to be legally bound for myself, my child, my heirs, assigns, executors, or administrators, understand and recognize and warrant that this Release and Hold Harmless Agreement is being voluntarily and intentionally agreed to and signed. This agreement waives and forever releases, acquits, discharges and holds harmless all claims for damages against ITRP or Schaefer Livestock dba Box T Barn and Stables.

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Liability – Hold Harmless – Assumption of Risk 2017 (Continued)

Participant's/Volunteer's Name (Please Print):_____
Participant's/Volunteer's Signature: _____
Print name of minor: _____

Print Name of adult/legal guardian:_____

Signature of adult/legal guardian: _____

Date: _____

Witnessed by: _____

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Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be confidential except as in necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurances payers as is necessary and appropriate for your care. Patient files may be stored in open files racks and will not contain any coding with identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns of complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Participant Photo Consent Form 2017

Participant Name (Please Print):_____

I hereby authorize Innovative Therapeutic Riding Program (ITRP) the use of my Name, picture, video, and/or audio or digital recording, associated with the ITRP program. I expressly waive any and all rights which I may have, under any applicable local, state, and federal laws or any common law claim, against ITRP and/or Schaefer Livestock dba Box T Barn and Stables or/any staff, board member, volunteers or instructors. I hereby agree to and consent to the foregoing assignment and waiver.

Participant Signature: _____

Date:_____

Parent or legal Guardian (if under 18): _____

Date:_____

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