Dear New Student/Family/Caregiver,

Thank you for your interest in Hearts Therapeutic Equestrian Center, a non-profit dedicated to enhancing the capabilities of children and adults with special needs in the Tri-county area since 1985.

Hearts is proud to provide the industry's best practices in Equine Assisted Activities and Therapies as a Premiere Accredited Center with PATH International (Professional Association of Therapeutic Horsemanship).

Hearts Therapeutic strives to keep our fees as low as possible as a service to our riders, while maintaining the optimum health of our horses and the provision of safe professional services. As a result, rider tuition only covers 30 % of the actual cost of each lesson. The remaining cost is funded through donations, grants, and fundraising events to ensure an affordable program for each rider.

Hearts' mission is to serve people with disabilities. Persons with disabilities are the sole recipients of scholarship assistance.

All rider applications must be completed, signed, and dated as indicated, and submitted prior to booking an assessment. The applicant will receive communication from the Hearts' Program office to schedule an assessment once the completed application has been received and reviewed by our Certified Therapeutic Riding Instructors. Assessments will determine the suitability of the applicant and the best placement for the rider in the Hearts program.

We look forward to serving you.

Sincerely,

Susan Weber
Program Director
Hearts Therapeutic Equestrian Center
susan@heartsriding.org
(805) 364-6238

Contact Information

For Questions regarding paperwork and scheduling, customer service concerns, and all other inquiries please contact:

Susan Weber, Program Director
susan@heartsriding.org
Office: 805-364-6238
Cell: 203-264-6198

For Questions Regarding Billing, please contact:

Jo Gause, Bookkeeper
jo@heartsriding.org
Office: 805-364-6239

For Lesson Cancellations, please contact the cancellation line:

Call: 805-364-5202
Email: morgan@heartsriding.org

Billing Information

Students are enrolled at Hearts on a semester basis and assume responsibility for the full tuition of the months in which they are enrolled. Riders who enroll at Hearts will be automatically billed through the auto-billing system. Please complete the following Credit Card Authorization Form.

Hearts will deliver 45 weeks of riding in 2018. To establish monthly fees, tuition for 45 weekly lessons was pro-rated across 12 months of the year. Therefore, monthly tuition remains consistent throughout the semester, regardless of when any lesson breaks occur.

Fees

- Group Lesson Tuition $240 per month
- Private Lesson Tuition $320 per month
- Registration fee $50 one-time fee, due with first month tuition

Tuition Agreement

NO make-up lessons or refunds will be provided

Preparation for each lesson requires scheduling horses, volunteers, instructors, curriculum development, and financial support. Hearts secures these valuable resources in anticipation of every lesson and is therefore unable to provide a refund or make-up lesson should a rider cancel or not show.

Hearts is also committed to providing therapeutic lessons, mounted or unmounted, despite inclement weather, and will NOT cancel lessons unless there is lightening, flood, or sever weather. Should participants have any questions as to whether Hearts is open for lessons due to holiday, inclement weather or otherwise, call the office at (805) 964-1519.

Adjustments to tuition will be negotiated on an individual basis in the case of extended, unexpected medical conditions that prevent riding. Financial assistance may be available for therapeutic riders only. Please contact the office for details.

Participants MUST provide written notice to discontinue participation in the Hearts Riding Program no later than **30 days prior** to the next billing cycle. Should a participant wish to place their tuition on hold for anticipated absences, Hearts will require **30 days** written notice and a **$75 hold fee** for each month a participant will be absent from the Program.

The signature of the financially responsible party below signifies an understanding of and agreement to pay tuition according to the guidelines listed above.

Rider's Name _____ Email Address:_____

Signature _____ Print Name _____ Date_____

PO Box 30662, Santa Barbara, CA 93130
805-964-1519 www.heartsriding.org

HEARTS Therapeutic equestrian center

PREMIER ACCREDITED CENTER PATH

AUTOMATIC BILLING AUTHORIZATION

Name on Card:_____

Billing Address:_____

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

Phone:_____ **Email:**_____

Participant's Name:_____

I hereby authorize Hearts Therapeutic Equestrian Center to charge my card on the 10th of each month for the following amount:

Group Lesson	$240.00 _____	**Private Lesson**	$320.00_____
One-Time Registration Fee	$50.00 _____	**Lesson Hold Fee**	$75.00 _____
Other	$_____ _____		

Credit Card:_____ Expiration: _____ Code: _____

Signature: _____ Date: _____

Email or drop off your automatic billing form to:
Hearts Therapeutic Equestrian Center
4420 Calle Real Rd.
Santa Barbara, CA 93111
Phone: 805.964.1519
info@heartsriding.org

For Office Use Only

Participant Start Date:

Participant Application & Health History

Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

E-mail: _____ Phone: _____ Alternative #:_____

Emergency Contact: _____Phone: _____

Parent/Legal Guardian/Caregiver: _____

How did you hear about our program: _____

Previous horse/riding experience: _____

Rider Health History

Primary Diagnosis: _____ Date of onset: _____

Secondary: _____ Date of onset: _____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/joint			
Muscular			
Thinking/Cognition			
Allergies			

Medications (include prescription and over the counter, name, dose and frequency):

_____

_____

_____

_____

Please describe your abilities/difficulties in the following areas

Physical Function

Mobility skills, assistance required or equipment needed, i.e. transfers, walking, wheelchair, driving/bus riding etc.

_____

_____

_____

Psycho/social Function

Work or school environment (grade completed), leisure interests, relationships/family structure, support systems, companion animals, fears, anxieties, concerns, etc.

_____

_____

_____

General Goals: Why are you applying for participation? What would you like to accomplish?

Examples: Improved confidence, balance, speech, endurance, posture, focus, social development, etc.

_____

_____

_____

Life Goals: What would you like to improve in your everyday life?

Examples: Ride a bike, make a friend, develop coping skills for anxiety, appropriate behavior, etc.

_____

_____

_____

Signature: _____ **Date:** _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency treatment / aid is required due to illness or injury during the process of receiving services, or being on the property of the agency, I authorize *Hearts Therapeutic Equestrian Center* to:

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.

Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

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 invoked if the person listed below is unable to be reached.

Date: _____ Consent Signature: _____

Client, Parent, or Guardian

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: _____ Non-Consent Signature: _____

Client, Parent, or Guardian

PO Box 30662, Santa Barbara, CA 93130
805-964-1519 www.heartsriding.org

HEARTS Therapeutic equestrian center

PREMIER ACCREDITED CENTER PATH

Dear Health Care Provider:

Your patient is interested in participation in supervised equine assisted activities and therapies at Hearts Therapeutic Equestrian Center. In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form.

Name: _____ DOB: _____ Age: _____

Gender: M F Height: _____ Weight: _____ Pulse: _____ BP: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Medications (type, purpose, & dose): _____

_____

If Down Syndrome, Atlanto-Axial Subluxation? Yes _____ No_____

All students with Downs Syndrome must have written, signed documentation as a result of a neurological exam.

Results: Positive _____ Negative _____ Exam date: _____

Tetanus Shot: Yes _____ No _____ Date: _____

Please note that the following conditions may suggest precautions and contraindications to equine assisted activities and therapies. Therefore, when completing the form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability (include neurologic symptoms)
Coxa Arthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossifications
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Join Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizures
Spina Bifida/Chiari II Malformation
Tethered Cord/Hydromyelia

Other
Indwelling Catheters
Medications- i.e. photosensitivity
Poor Endurance/Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Hemophilia
Migraines
Fire Setting
PVD
Recent Surgeries
Substance Abuse
Respiratory Compromise
Thought Control Disorders
Weight Control Disorders
Medical Instability
Blood Pressure control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Physical/Sexual/Emotional Abuse

HEARTS Therapeutic equestrian center

PREMIER ACCREDITED CENTER PATH

Participant Medical History

to be completed by Physician

PROBLEM	YES	NO	IF YES, DESCRIBE
AUDITORY IMPAIRMENT	____	____	_____
LEARNING DISABILITY	____	____	_____
MENTAL IMPAIRMENT	____	____	_____
PSYCHOLOGICAL IMPAIRMENT	____	____	_____
SPEECH IMPAIRMENT	____	____	_____
VISUAL IMPAIRMENT	____	____	Glasses: _____
ALLERGIES	____	____	_____
CARDIAC	____	____	_____
CIRCULATORY	____	____	_____
PVD	____	____	_____
Postural Hypotension	____	____	_____
Hemophilia	____	____	_____
PULMONARY	____	____	_____
Asthma / COPD	____	____	_____
NEUROLOGICAL	____	____	_____
Seizures	____	____	_____
Controlled?	____	____	Type: _____
Last Seizure:	____/____/____		_____
Hydrocephalus	____	____	_____
Shunt	____	____	# Revisions: _____
Sensory Loss	____	____	_____
Pain	____	____	_____
MUSCULAR	____	____	_____
Contractures	____	____	_____
SKELETAL	____	____	_____
Spinal Column Injury	____	____	_____
Subluxing Joints	____	____	_____

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HEARTS Therapeutic equestrian center

PREMIER ACCREDITED CENTER PATH

Dislocating Joints ____ ____ _____

Laminectomy / Fusion ____ ____ _____

Scoliosis ____ ____ Degree: _____ Type:_____

Brace: _____ Last X-ray: _____

Kyphosis / Lordosis ____ ____ Degree: _____ Type:_____

Spondylolisthesis ____ ____ _____

Spinal Abnormality ____ ____ _____

Osteoporosis ____ ____ _____

Heterotrophis Ossification____ ____ _____

Joint Disease ____ ____ _____

MOBILITY STATUS

Ambulatory Yes ____ No ____

Can the student ambulate independently? Yes ____ No ____

If No, describe: _____

PROSTHETICS / ORTHODONTICS

Type: _____ Purpose: _____

Physician Statement:

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Titles: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Office Address: _____

Phone Number: _____ License/UPIN Number: _____

Participant's Consent for Release of Information

I hereby authorize: _____
(Physician, person or facility)

to release information from the records of: _____ DOB: _____
(Participant's name)

The information is to be released to: HEARTS THERAPEUTIC EQUESTRIAN CENTER
(PATH International Therapeutic Center)

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- ☐ Medical history
- ☐ Physical therapy evaluation, assessment and program plan
- ☐ Speech therapy evaluation, assessment and program plan
- ☐ Mental health diagnosis and treatment plan
- ☐ Individual Habilitation Plan (IHP) Classroom
- ☐ Individual Education Plan (IEP) Psychosocial
- ☐ evaluation, assessment and program plan Cognitive-
- ☐ behavioral management plan
- ☐ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: HEARTS THERAPEUTIC EQUESTRIAN CENTER

P.O. Box 30662

Santa Barbara, CA 93130

OR email to susan@heartsriding.org

Waiver and Release of Liability

Name:_____

Program Participant *(if under 18):*_____

Mailing Address:_____

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

I acknowledge that horseback riding or activities involving horses is an extreme test of a person's physical and mental limits and carries with it the potential for serious injury, personal property loss or even death. Horses are large animals and even the gentlest horse can be unpredictable. I hereby assume the risk of participating in such activities.

I hereby take the following action for myself and my executors, administrators, heirs, next of kin, successors and assigns:

a) I waive, release and discharge from any and all claims or liabilities for death, personal injury or damages of any kinds, which acts arise out of or relate to my participation in, or my traveling to and from, the horseback riding events, the following persons or entities: Hearts Therapeutic Equestrian Center, building or facility lessees, sponsors, and the officers, directors, employees, representatives, instructors and agents of the above.

b) I agree not to sue any of the persons or entities mentioned above for any of the claims or liabilities that I have waived, released or discharged herein, and

c) I indemnify and hold harmless the persons or entities mentioned above from any claims made or liabilities assessed against them as results of my actions and any attorney fees or costs incurred by them as a result of my action.

Photo Release:

___ I hereby consent to and authorize the following, OR

___ I do not consent to, nor do I authorize:

Hearts Therapeutic Equestrian Center's use and reproduction of any and all photographs and other audiovisual material taken of me for promotional printed materials, social media, educational activities, exhibitions, or for any other use for the benefit of the program.

Confidentiality Agreement:

I understand that all information (written and verbal) about participants at this PATH center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

By signing this form, I affirm that I am eighteen (18) years of age or older, I have read this document, and I understand its contents.

Signature: _____ Date: _____

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