HOPE – HOrses helping PEople, Inc.

Eligibility Requirements & Admittance Process

Eligibility: Any person diagnosed with an emotional, physical, cognitive disability from age 2 and up is eligible to apply for enrollment into one of HOPE's programs. There are additional requirements that clients must first meet before we can enroll them in our program.

1. The first step is to contact the Therapy Director at HOPE to discuss space availability. We do maintain a waiting list and move people off the list readily. Once an open spot is determined, the client, client's parent(s), or legal guardian must fill out copies of all the HOPE's enrollment forms. No client may begin until all forms are received. The enrollment forms can be found on our website or may be obtained through the mail or email.

2. The client and his/her parent(s) or caregivers must attend a preliminary evaluation and intake meeting with HOPE's Therapy Director. This intake and evaluation process is in place to help establish the best treatment plan possible for each individual client. It is also the time that precautions and contraindications to equine assisted therapy for particular disabilities are reviewed and discussed on an individual basis.

3. For health of our horses and the safety of our clients and side walkers, we generally do **not accommodate clients in excess of 200 lbs**. Alternative means of interaction with horses will be recommended for individuals who would still like to participate in an equine-facilitated activity. If you have any questions about the suitability of any of our Equine Assisted Activities and Therapies for you, please do not hesitate to contact HOPE's Therapy Director.

4. Clients with specific treatment plans that include specialized emergency procedures, medical prescriptions, or actions to be taken around behavioral issues must have a parent or caregiver accompany them to each session.

5. HOPE currently accepts clients starting at age 2. Clients younger than 2 years may be accepted depending upon the findings of the initial intake with HOPE's Therapy Director and at HOPE's discretion. Generally speaking, children with disabilities between ages of 2-5 and adults with acute or sub-acute disability related issues are typically enrolled in HOPE's Equine-Assisted Therapy program. Older clients who are able are typically enrolled in Adapted Riding or Grooming. Although HOPE utilizes many different staff, volunteers and horses, some clients are difficult to provide for because of a physical, mental or behavioral challenge that scares or threatens those around them, most especially the horses. HOPE staff will attempt to create the best rider, horse, staff and volunteer combination possible. HOPE reserves the right to deny or remove a client from a equine-assisted therapy/activity session if their actions jeopardize the safety of the horses, staff, or him/herself.

HOPE – HOrses helping PEople, Inc.

Client Information and History

GENERAL INFORMATION

Client Name: _____

Date of Birth: _____Age:_____ Sex: M F Height:_____ Weight:_____

Address: _____City _____ State_____ Zip_____

Email:_____ Phone: _____Mobile:_____

Employer/School:_____

Address:_____

Parent/Guardian Name(s) _____

Address: _____City _____ State_____ Zip_____

Email:_____ Phone: _____Mobile:_____

How did you hear about our program?_____

HEALTH HISTORY

Diagnosis (& ICD-10 code):_____

Primary Physician:_____ Phone #:_____

Please list any other professionals and agencies that you are currently working with (or note if worked with in the past):

Specialist Physician:_____ Neurologist:_____

Physical Therapist:_____ Speech Therapist:_____

Psychologist/Counselor:_____ Occupational Therapist:_____

Developmental Optometrist:_____ Behaviorist:_____

Orthopedist:_____ Other:_____

Are there any precautions the therapist should be aware of when working with your child? □ No □ Yes

If yes, when and what:_____

_____

What medications is the patient currently taking, including over-the-counter medications? _____

_____

_____

HOPE – HOrses helping PEople, Inc.

Client's Consent for Release of Information

I hereby authorize Hope Horses Helping People:

To release information from the records of: _____
(client's name)

The information is to be release to Hope Therapy for the purpose of developing a

Therapeutic Riding Program for the above named student. The information to be release is marked below:

___ Medical History

___ Physical Therapy evaluation, assessment and program plan

___ Occupational Therapy evaluation, assessment and program plan

___ Speech Therapy evaluation, assessment and program plan

___ Classroom Individual Education Plan (I.E.P)

___ Other: _____

Date: _____ Signature: _____
(Client, Parent or Guardian)
Please send the indicated material to: ***HOPE Horses Helping People***

HOPE – HOrses helping PEople, Inc.

Please describe the patient's abilities/difficulties, limitation/concerns in the following areas, including assistance required or equipment needed:

PHYSICAL FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use)
Can patient sit independently? □ Yes □ No Walk Independently? □ Yes □ No

_____
_____
_____
_____
_____

PSYCHO/SOCIAL FUNCTION (i.e. work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)

_____
_____
_____
_____
_____

COGNITION AND PROCESSING (i.e. attention, touch/sensation, memory, speech and language, sensory integration, learning disabilities, developmental delays)

_____
_____
_____
_____
_____

GOALS (i.e. why are you applying for participation? What would you like to accomplish?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HOPE – HOrses helping PEople, Inc.

EMERGENCY MEDICAL TREATMENT FORM

Name: _____ DOB: _____

Address: _____

City: _____ Zip: _____

Physician's Name: _____ Preferred Medical Facility _____

Health Insurance Company:_____Policy#_____Group #_____

Allergies: _____

Current Medications: _____ Date of Last Tetanus Shot: _____

In the event of an emergency, contact:

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 HOPE – HOrses helping PEople, Inc. 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.
3. I agree to assume sole responsibility for all charges fro such treatment.
4. I understand that the Emergency Release Treatment Form will be placed in the barn area, accessible to others, for use only in case of emergency.

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(s) above is unable to be reached.

Date:_____Consent Plan Signature:_____

Client, Parent or Legal Guardian, **signed**

OR

Non-Consent Plan: I do not give 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.

1. Parent or legal guardian will remain on site at all times during equine assisted activities
2. In the circumstance that I am not on site in violation of HOPE Horses Helping People policy, I will be financially responsible for any emergency treatment .In the event emergency treatment/aid is required, wish the following procedure(s) to take place:_____

_____

_____

Date: _____ Non-Consent Signature:_____

Client, Parent or Legal Guardian, **signed**

HOPE – HOrses helping PEople, Inc.

Payment Agreement

I understand the therapist will help bill insurance and deductibles/co-payment is due by cash or check at the time of treatment, unless prior arrangements have been made. Paperwork for submittal of insurance claims independently may be requested. I understand and accept ultimate responsibility for payment of my account.

I have read and understand this policy
Client Signature: _____Date:_____
Parent/Guardian Signature (if under 18): _____

I am Paying by CASH, CHECK, CREDIT and would like a….
☐ 35% discount by paying at the time of service.
☐ Payment plan. Fees may apply.
Or
Guarantor/Insured Party

Credit Card ___Visa___MC___AmerX___Discover
Card#_____ExpDate_____
Name on Card_____CVV code____

Insured's Full Name:_____Date of Birth:_____
Relationship to Client:_____
Primary Insurance Company Name:_____
Policy Number:_____ Group Number: _____Deductible/Co-_____
Insurance Company Address: City: _____ State:_____Zip: _____ Phone: _____

Insured's Full Name:_____Date of Birth:_____
Relationship to Client:_____
Secondary Insurance Company Name:_____
Policy Number:_____ Group Number: _____Deductible/Co-pay:_____
Insurance Company Address: City: _____ State:_____Zip: _____ Phone: _____

ASSIGNMENT OF BENEFITS
I hereby assign all medical benefits to which I am entitled to Cathi Brown, MOT, OTR/L in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event any account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debit.

I have read and understand this policy
Client Signature: _____Date:_____
Parent/Guardian Signature (if under 18): _____

MEDICAID/PAYMENT AUTHORIZATION
As a Medicaid patient, I certify that the information given by me in applying for payment is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made to Cathi N. Brown, MOT, OTR/L at HOPE Horses Helping People, Inc. on my behalf. I also certify that I will provide all necessary paperwork/documentation/notifications to Cathi N. Brown, MOT, OTR/L at HOPE Horses Helping People, Inc. immediately if there is a change in my Medicaid status. I also certify that I will provide Cathi N. Brown, MOT, OTR/L at HOPE Horses Helping People, Inc with all necessary paperwork so that this provider can effectively bill Medicaid and/or my primary insurance company in a timely manner. I certify that failure to do so on my part, I will be personally financially accountable and liable for private pay therapy rates for the services rendered to me and/or my family member/ child.

I have read and understand this policy
Client Signature: _____Date:_____
Parent/Guardian Signature (if under 18): _____

HOPE – HOrses helping PEople, Inc.

PARTICIPATION AGREEMENT

I, _____ (Client's/Parent's/Guardian's Name), hereby agree that I will schedule and attend prescribed therapy sessions with the patient (or assign a consistent caregiver to do so) and will be responsible for implementing the home program and strategies as recommended by the therapist(s) in order to facilitate progress toward the patient's goals. I understand that Occupational Therapy is medically prescribed treatments and that failure to comply with the therapist's recommendations implies to the referring physician an unwillingness to participate in therapy recommendations.

In order for your therapist to provide the best possible treatment for the patient, it needs to be understood that patient/caregiver cooperation and participation with a "home program," "carryover program," or "recommendations" be followed and charted/documented in the home setting in order to determine measurable benefits of the program or the need to modify a treatment strategy. It is understood that should recommendations not be completed three consecutive treatment times in a row, the patient will be discharged from therapy.

I have read and understand this policy
Client Signature: _____Date:_____
Parent/Guardian Signature (if under 18): _____

Cancellation Policy

In order for your therapist to provide the best possible treatment for the patient, it also needs to be understood that the patient/caregiver must cooperate with HOPE-Horses Helping People, Inc. in scheduling and attending prescribed, regular treatment sessions. Frequent cancellations, tardiness, gaps in treatment visits, and no-shows will result in monetary charges and/or discharge from therapy.
Cancellations/Make-ups: I understand that if I must cancel a session, a 24-hour notice is required. I understand that failure to notify the therapist of a cancellation 24 hours ahead of time will result in the normal cost of therapy session being charged. I also understand that I may reschedule any cancelled therapy sessions depended on availability. We recognize and assess individual needs.

I have read and understand this policy
Client Signature: _____Date:_____
Parent/Guardian Signature (if under 18): _____

Photo Release

☐ I do ☐ I Do Not
Consent to and authorize the use and reproduction by HOPE – HOrses helping PEople, Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the center.
Date: _____
Client Signature: _____
Parent/Guardian Signature (if under 18):_____

CONSENT TO RECEIVE SERVICES
I hereby authorize Cathi N. Brown, MOT, OTR/L at HOPE Horses Helping People to render appropriate health care to patient named above. I recognize and agree that I have the right to refuse treatment or terminate services by Cathi N. Brown, MOT, OTR/L at HOPE Horses Helping People, Inc. In addition, Cathi N. Brown, MOT, OTR/L at HOPE Horses Helping People, Inc. may terminate services by notifying me of termination and the reason.

I have read and understand this policy
Client Signature: _____Date:_____
Parent/Guardian Signature (if under 18): _____

HOPE – HOrses helping PEople, Inc.

STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

As an Out-Patient client you have the right to:

1. Be given information about your rights and responsibilities for receiving therapy services
2. Receive a timely response from the therapy company regarding your request for therapy services.
3. Be given information of the therapy company's policies, procedures, and charges for services.
4. Choose your therapy providers
5. Be given appropriate and professional quality therapy services without discrimination against your race, creed, color, religion, sex, national origin, sexual preference, handicap, or age.
6. Be treated with courtesy and respect by all who provide therapy services to you.
7. Be free from physical and mental abuse and or neglect.
8. Be given proper identification by name and title of everyone who provides therapy services to you.
9. Be given necessary information so you will be able to give informed consent for your treatment prior to the start of any treatment.
10. Be given complete and current information concerning your diagnosis, treatment, alternatives, risks and prognosis as required by your physician's legal duty to disclose, in terms and language you can reasonably be expected to understand. 11. A plan of care that will be developed to meet your unique health care heeds.
12. Participate in the development of your health care plan.
13. Be given an assessment and update of your developed health care plan.
14. Be given data and privacy and confidentiality.
15. Review your clinical record at your request with prior notice and physician's order.
16. Be given information regarding anticipated transfer of your therapy care to another health care provider and /or termination of therapy services to you.
17. Voice grievance with and/or suggest change in therapy services and/or therapist without being threatened, restrained, and/or discriminated against.
18. Refuse treatment within the confines of the law.
19. Be given information concerning the consequences of your refusing treatment.

As an Out-Patient client you have the responsibility to:

1. Give accurate and complete health information concerning your past illnesses, hospitalization, medication, medications, allergies, and other pertinent items.
2. Assist in developing and maintaining a safe environment
3. Inform the therapy company when you will not be able to keep a therapy visit.
4. Participate in the development and update of your health care plan.
5. Adhere to your developed/updated health care plan.
6. Request further information concerning anything you do not understand.
7. Give information regarding concerns and problems you have to the therapist/therapy company.

STATE OF FLORIDA: Department of Health and Rehabilitative Services

TO REPORT ABUSE, NEGLECT, OR EXPOLOITATION, PLEASE CALL TOLL FREE 1-800-96-ABUSE. THIS SERVICE IS AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK.

I understand my Bill of Rights and have received a copy of it.

Client Signature: _____Date:_____
Parent/Guardian Signature (if under 18): _____

HIPPA and NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPPA) were established by the US government to establish rules concerning the use and protection of medical and health information. The rules are intended to provide standard protections for your medical information. We regard the privacy of our patients as a central part of our mission to serve the needs of the patient first. Private controlled used of your information is essential to your care. The Notice of Privacy Practices provides you with information explaining how we use your medical information. I acknowledge that I have been offered a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act, I understand that this acknowledgement means only that I have received the notice and in no way affects the care I receive.

Client Signature: _____Date:_____
Parent/Guardian Signature (if under 18): _____

HOPE – HOrses helping PEople, Inc.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND

HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out the formulation of an equine-assisted occupational therapy program and /or participation at HOPE-Horses Helping People, Inc., and/or for payment and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved with you for the purpose of your participation at HOPE-Horses Helping People, Inc. and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your participation at HOPE-Horses Helping People, Inc. and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a staff member or volunteer to assist them in helping you.

Payment: Your protected health information may be used, as needed, to obtain payment for your services. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization or opportunity to object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that HOPE-Horses Helping People, Inc. has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. HOPE-Horses Helping People, Inc. is not required to agree to a restriction that you may request. If they believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another riding program.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate **against you for filing a complain**

HOPE – HOrses helping PEople, Inc.

"BARN RULES" Please keep for your records.

 Please arrive at least 10 minutes early for your appointment and have your child prepared for their riding session (bathroom duties, etc.).

1. All riders **must wear appropriate clothing** for equine activities every time:
    1. Wear closed toe shoes: Boots or sneakers only! No Sandals, flip-flops, or open toes are to be worn by anyone riding or not, as you may get your toes stepped on by a horse. Parents, THIS INCLUDES YOU TOO!
    2. Wear long pants: (If a saddle is to be used) Jeans or material pants are okay. (No shorts or capri pants that end midcalf). The riders legs may become chafed against the leather of the saddle if not protected by long pants.
    3. Wear Sunglasses and Sunblock: It is hot in Florida, so protect all exposed areas.
    4. Helmets: If you own an approved equestrian riding helmet, please bring it. If not, we have many that are available to be borrowed for your session.
2. Please be careful to fully hydrate prior to riding. Water is the best way to hydrate BEFORE and DURING your ride. Bring bottled water each session.
3. Please immediately notify us of any health or behavioral changes you may have noticed in your child at the beginning of your session. We like to stay informed!
4. In the case of inclement weather, we will notify you by phone if your session will be cancelled or delayed. As we know, in Florida, it may be raining in one area, but sunny a few blocks away. Your session will run as scheduled unless you receive a call from us. If you do not come to your session, you will be charged a $40 fee.
5. We require 24 hours notice of cancellation in order to avoid a "No-Show" fee.
6. Please remember that it takes a lot of time and effort from the staff, volunteers, and horses to run a smooth program, therefore anyone who "No-Show's" more than 2 times may be asked not to return. We understand that emergencies do arise, therefore we are always reachable by phone during business hours.
7. Please inform us of an address or phone information change.
8. Please Do Not Feed the Horses or any other animal. All animals bite and can kick.
9. Supervise all children/siblings while on the premises, as there are natural hazards such as open water on site. All children must be supervised in the bathroom area.
10. You may not walk around the barn without the direct supervision your instructor.
11. Please do not climb on fences or the mounting block while lessons are running. Please seat yourself adequately far from the mounting block to avoid potential accidents and distractions.
12. Please remember that you are a GUEST at our facility. Please respect our property, staff, volunteers, animals and other guests. We are a place of HEALING therefore any loud, rude, obnoxious, or otherwise inappropriate behavior will be reason to be invited to leave the premises immediately. We insist on keeping our program in a positive atmosphere, so if you have personal issues or complaints, make sure you only discuss them in private with staff or wait until you can reach your therapist or instructor by phone. Privacy & Courtesy are important!
13. Always call if you have any questions regarding the above policies.

HOPE – HOrses helping PEople, Inc.

FOR DOCTOR!! Attach with next page for physician signatures

PHYSICIAN'S STATEMENT

Dear Health Care Provider:

Your patient,_____ *(participant's name)* is interested in participating in equine-assisted therapy and activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form.

Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree. Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/ phone below.

Orthopedic	**Medical/Psychological**	**Neurologic**
Atlantoaxial Instability - include neurologic symptoms	Allergies	Hydrocephalus/Shunt
Coxa Arthrosis	Animal Abuse	Seizure
Cranial Deficits	Cardiac Condition	Spina Bifida/Chiari II malformation/Tethered Cord/ Hydromyelia
Heterotopic Ossification/ Myositis Ossificans	Physical/Sexual/Emotional Abuse	
Joint subluxation/dislocation	Blood Pressure Control	**Other**
Osteoporosis	Dangerous to self or others	Age - under 4 years
Pathologic Fractures	Exacerbations of medical conditions (i.e. RA, MS)	Indwelling Catheters/ Medical Equipment
Spinal Joint Fusion/Fixation	Fire Settings	Medications - i.e. photosensitivity
Spinal Joint Instability/ Abnormalities	Hemophilia	Poor Endurance
	Medical Instability	Skin Breakdown
	Migraines	
	PVD	
	Respiratory Compromise	
	Recent Surgeries	
	Substance Abuse	
	Thought Control Disorders	

Physician's Notes

_____

_____

_____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted therapies or activities, please feel free to contact the center at the address/phone number indicated below.

Prescription required stating Occupational Therapy to evaluate and treat and stating patient's diagnosis & ICD-10 code.

9722 SW 153rd Avenue · Archer, Florida 32618 · 352.495.0533

HOPE – HOrses helping PEople, Inc.

PHYSICIAN'S STATEMENT

Participant:_____DOB:_____Height:_____ Weight:_____

Address:_____

Phone:_____(h)_____(c)_____(w)

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled □ Y □ N Date of Last Seizure:_____

Shunt Present □ Y □ N Date of Last Revision: _____

Special Precautions/Needs: _____

Independent Ambulation: □ Y □ N Assisted Ambulation: □ Y □ N Wheelchair: □ Y □ N Braces/Assistive Devices:_____

For those with Down Syndrome:

AtlantoDens Interval X-rays Date:_____ Result: + -- Neurological Symptoms of AtlantoAxial Instability:_____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted therapy and activities. I understand that Cathi Brown, MOT, OTR/L and HOPE Horses Helping People will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Cathi Brown, MOT, OTR/L and HOPE Horses Helping People for ongoing evaluation to determine eligibility for participation.

Name/Title: _____MD DO NP PA Other _____

Physician's Signature: _____ Date: _____

Address: _____

City:_____State_____Zip_____

Phone:_____ License/UPIN Number:_____

HOPE – HOrses helping PEople, Inc.

EQUINE ACTIVITY LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS
READ BEFORE SIGNING

This Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risks Agreement (the "Agreement") is hereby given by _____ on his/her own behalf HOPE – HORSES HELPING PEOPLE, INC., a Florida not for profit corporation, as the equine activity sponsor (the "Sponsor"), and to each officer, director, agent, employee, volunteer, equine professional (as defined in the Act referenced herein), instructor, therapist, aide, heir, personal representative, successor and/or assign of the Sponsor (who also shall be included within the word "Sponsor") and agrees as follows:

In consideration for the opportunities provided by the Sponsor to the undersigned, including any minor or legal ward in whose behalf the undersigned signs this Agreement (collectively, the "Participant"), for the enjoyment of equine activities and the use of the Sponsor's facility and equipment, the Participant hereby agrees as follows:

1. This Agreement is given in part under the Florida Equine Activities statutes (Chapter 773) as it may now provide or be hereafter amended (the "Act"). All terms defined by the Act shall have the same meaning herein, and the Act is hereby incorporated in this Agreement by reference. This Agreement shall be so construed as to provide to the Sponsor the fullest protection of a release, waiver of claim and recovery, right to sue and assumption of all risks that is afforded by the Act, and by other applicable statutes and general law.

2. The Participant hereby acknowledges that he/she has full and complete notice and understanding of the Act and of all the dangers and/or conditions which are an integral part of equine activities which may cause, contribute to or result in the death or personal injury of the Participant or damage to the Participant's property (the "Risks"), including, but not limited to:

- The propensity of equines to behave in ways (such as, but not limited to, buck, stumble, fall, rear, bite, kick, run, and make unpredictable movements, spook, jump obstacles, step on a person's feet, push or shove a person, saddles or bridles may loosen or break) that may result in injury, harm, or death to persons on or around the equine;
- The unpredictability of an equine's reaction to sounds, sudden movement, persons, other animals, or unfamiliar objects.
- Hazards, including, but not limited to, surface or subsurface conditions;
- A collision with another equine, another animal, a person, or an object;
- The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including, but not limited to failing to maintain control over an equine or failing to act within the ability of the participant.
- The inability of anyone whomsoever to predict or foresee an equine's reaction to excitement, weather conditions, sound, movements, objects, vehicles, persons, animals, reptiles, birds or insects, and the effects of such reactions.
- The dangers and risks of tack or harness, loosening, slipping or breaking for whatever reason.
- The dangers and risks of becoming entangled in tack, harness, or vehicles used in an equine activity.
- The risks of falling from or otherwise becoming unstable on an equine or a vehicle used in an equine activity for any reason whatsoever or for no identifiable reason.
- Any negligent act or omission by the Sponsor which causes or results in the death or personal injury of the Participant or damage to the Participant's property.

3. The Participant hereby expressly assumes all risks and dangers of injury, loss, damage or death which are in any way resulting from the inherent risks of equine activities and/or associated with the Risks enumerated in paragraph 2 above.

4. The Participant hereby releases and waives all rights which he/she may have or hereafter have against the Sponsor for injury, loss, damage or death which is in any way resulting from the inherent dangers of equine activities and/or associated with the Risks enumerated in Paragraph 2 above, and the right to sue or to bring any action against the Sponsor in connection therewith. The Participant agrees to completely indemnify and hold the

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Sponsor harmless from and against any and all claims, demands, causes of action, suits, actions, losses, liabilities, costs and/or expenses, including medical costs and attorney's fees, which are occasioned by, or otherwise attributable to, matters for which the Participant has hereby assumed the risk and is responsible in accordance with this Agreement.

5. The Participant agrees to comply with all rules and regulations posted or otherwise communicated by the Sponsor. The Participant agrees that the Sponsor has made reasonable and prudent efforts to determine the Participant's ability to engage in the Equine Activity offered by the Sponsor and the Participant has disclosed all known physical and psychological conditions
to Sponsor to assist Sponsor in evaluating the Participant for participation in the Equine Activity offered by the Sponsor.

6. The Participant agrees that mounting, riding, walking, dismounting, grooming, training, handling, feeding, and otherwise being in the physical proximity of horses is a dangerous activity which produces a foreseeable risk o mortal or serious personal injury and/or property loss to the Participant in such activity as well as to the person or property of others.

7. This Agreement shall remain valid and in full force and effect from and after the date opposite the signature of the Participant until expressly revoked by the Participant in a written notice personally delivered to the Sponsor.

8. This Agreement shall be construed under Florida law in such manner as will render it, and each provision of it, fully enforceable; provided, however, that if any provision of this Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Agreement shall continue in full force and effect. Venue for purposes of any litigation or arbitration concerning this Agreement shall be in Alachua County, Florida.

9. If this Agreement is executed by the undersigned for and on behalf of a minor Participant as named below, the undersigned hereby warrants and represents that he/she is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor Participant, his/her heirs,
personal representatives, successors and assigns; and the undersigned further agrees that this Agreement shall also be as fully binding on the undersigned as if it were entered into solely on his/her own behalf.

10. This Agreement shall be binding upon the heirs, personal representatives, successors and assigns of the Participant and the undersigned.

WARNING

Under Florida law, an equine activity sponsor or 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.

I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING EQUINE LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS. I HAVE CONSULTED AND RELIED UPON MY OWN ADVISORS ON ALL QUESTIONS IN CONNECTION THEREWITH AND FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT. I HAVE NOT RELIED UPON THE SPONSOR FOR ANY ADVICE OR EXPLANATION IN CONNECTION THEREWITH.

IN WITNESS WHEREOF, I have set my hand this ____ day of _____, 201

_____ _____

(Signature of client or client representative) (Printed name)

In the presence of:_____(Witness)

FOR MINORS UNDER 18 YEARS OF AGE:

Print Name of Minor (client) _____

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Anthony and Nanette Mancuso (and Helping Hooves, LLC)
15304 SW 91st Street
Archer, FL 32618
(352) 495-4399

LIABILITY RELEASE AGREEMENT NOT TO SUE AND INDEMNITY AGREEMENT

I, _____, desire to take horseback riding lessons, engage in therapeutic horse riding or hippotherapy activities under the auspices of a tenant on the property of Anthony and Nanette Mancuso and/or use the horses and facilities of Helping Hooves, LLC and Anthony and Nanette Mancuso's horses and farm and residence, acknowledge that horseback riding and activities incidental thereto are inherently dangerous activities, and further acknowledge that serious injury can result from engaging in horseback riding and activities incidental thereto. In connection with the use and enjoyment of the horses and facilities of Helping Hooves, LLC and Anthony and Nanette Mancuso's horses, farm and residence and/or the furnishing of horseback riding lessons to me and/or therapeutic use of horses for my benefit, I agree on behalf of myself, and my heirs and legal representatives forever to release any member of Anthony and Nanette Mancuso's family and Helping Hooves, LLC and all of their past, present and future employees, tenants on their horse farm property and their respective heirs and legal representatives from, and agree no| to sue in connection with any and all damages, claims, demands, rights, and causes of' action based upon personal injuries or property damage to me or my death, arising out of horseback riding, lessons, the use of the horses and facilities of Anthony and Nanette Mancuso and Helping Hooves, LLC including stables, grounds, or any activities incidental thereto. I further agree to indemnify Helping Hooves, LLC and Anthony and Nanette Mancuso and to save them harmless from all damages, actions, causes of actions, claims, judgments, executions, debts, cost of litigation and attorney's fees, which may in any way rise out of or result from the furnishing of horseback riding lessons to me, therapeutic use of horses for my benefit and/or the use of the horses or facilities of Helping Hooves, LLC or Anthony and Nanette Mancuso including stables and grounds, by me and/or any activities incidental thereto at any time from the date of this Release until this Release is expressly revoked by me.

I have read and understand the above Release of Liability, Agreement Not To Sue And Indemnity Agreement, and that by executing this Agreement I acknowledge that I am giving up valuable rights.

IN WITNESS WHEREOF, I have set my hand this ____ day of _____

_____ _____
(Signature of participant or guardian) (Printed name of participant)
In the presence of:_____(Witness)

WARNING!!! UNDER FLORIDA LAW, an equine activity sponsor or equine professional is not liable for injury to, or the death of, a participant in the equine activities resulting from the inherent risk of equine activities.