Welcome to Therapy Services at Ride On!

To get started please fill out the following paperwork with all requested information. You may submit your paperwork via email at Office@Rideon.org, by fax (805) 309 – 5234 or at your nearest Ride On location. Once we receive your paperwork we will call you to schedule an evaluation. Following your initial evaluation, our therapists will determine if therapy services are an appropriate treatment strategy for you/your child. At your weekly scheduled therapy session we will have a licensed therapist (physical, occupational, or speech), highly skilled horse handler, well-trained horses and safety assistants (as needed).

What to expect during therapy sessions:
Therapy sessions are scheduled for 45 minutes and may include treatment on the horse, in the area of the barn, indoors in the clinic, transitioning on/off the horse, patient and family education, and discussions regarding progress /goals.

Payments:
Payments are due at the time of service or monthly automatic payments with a credit card on file. The rate per treatment is $120 for 45 minutes of therapy. Superbills can be provided upon request, for insurance reimbursement.

Cancellations:
Please provide as much notice as possible for upcoming cancellations. As we have several staff members (human and equine) involved with each session, and we have patients who may be able to fill in available time slots. You may be charged a fee if adequate notice is not given.

When our therapists are unavailable, we will have another therapist fill-in whenever possible.

During inclement weather (heat, rain, or wind) therapy may take place indoors, or may be cancelled. If there is any question, please call your therapist or our office to determine the status.

No-show/Late Cancellation Policy
Ride On will charge a $25 no-show or late cancellation fee, if we are not provided adequate notice to cancel an appointment.

Thank you for choosing Ride On to provide therapy for you/your child, we are looking forward to working with your family.

Sincerely,

Ride On
Patient’s Application and Health History

to be completed by the Patient, or Parent/Legal Guardian

GENERAL INFORMATION

Patient: ___________________________________________________________________________
Date of Birth: ______________ Age: ________ Height: ______________ Weight: _____ M F
Address: ___________________________________________________________________________
Phone: (___)_______________________ Alternative: ____________________________
Email: ___________________ ___________________________________________________________
Employer/School: _____________________________________________________________________
Address: ___________________________________________________________________________
Phone: (___)___________
Parent/Legal Guardian: __________________________________________________________________
Address (if different from above): ________________________________________________________
Phone: ______________________________________ ____________________________
Referral Source: ________________________________________________________________________
Contact numbers: _______________________________________________________________________
How did you hear about us? __________ ______________________

HEALTH HISTORY

Diagnosis: ___________________________________________________________________________________
Please indicate current or past problems in the following areas:

<table>
<thead>
<tr>
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<th>Y</th>
<th>N</th>
<th>Comments</th>
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<td>Thinking/Cognition</td>
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<td>Allergies</td>
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<td>Other</td>
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--- OVER ---

REV 11.17
What medications are you currently taking, including over the counter medications?

_____________________________________________________________

Describe your abilities/difficulties in the following areas, include assistance required or equipment needed:

FUNCTION  (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

SOCIAL  (i.e. Work/School including grade completed, leisure interests, relationships - family structure, support systems, companion animals, fears/concerns, etc. . . )

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

GOALS:  (i.e. What would you like to accomplish through therapy?)

____________________________________________________________________________________

___________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

SCHEDULE:  Please indicate preferences for location, day, time.  Also, indicate times you are unavailable.

CHATSWORTH:  YES / NO  NEWBURY PARK:  YES / NO

WEDNESDAY afternoon  Y / N  TUESDAY afternoon  Y / N
THURSDAY morning  Y / N  WEDNESDAY afternoon  Y / N
THURSDAY afternoon  Y / N  THURSDAY afternoon  Y / N
FRIDAY morning  Y / N  *Only PT Available

*Only PT Available

MEDIA/PHOTO RELEASE
I  CONSENT /  DO NOT CONSENT (circle one) to and authorize the use and reproduction by Therapy Services-RO of any and all photographs and any other audio-visual materials taken of me/my child for research, promotional material, social media, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: ________________________________________  Date: ______________

Patient, Parent or Legal Guardian

CONSENT FOR CARE AND TREATMENT
I, the undersigned hereby agree and consent for Therapy Services - RO to furnish care and treatment considered necessary and proper in treating my condition.

Signature: ________________________________________  Date: ______________

Patient, Parent or Legal Guardian
Patient’s Authorization for Emergency Medical Treatment

Please Print Clearly

Patient’s name: ______________________           Date of Birth: ___________         Phone: ___________
Address: ________________________________________________________________________________________________
Diagnosis: ________________________________________________________________________________________________
Physician’s Name: ______________________ Medical Facility: ______________________
Physician Address/phone: ________________________________________________________________________________________________
Health Insurance Co: ______________________ 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, and the above cannot be reached, I authorize therapy services or Ride On to:

1. Secure and retain medical treatment and transportation if needed.
2. Release patient 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 invoked if the person above is unable to be reached.

Date: ______________   Consent signature: ____________________________
Patient, Parent or Legal 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: ____________________________
Patient, Parent or Legal Guardian

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

--- OVER ---
Participants Release and Hold Harmless Agreement

This Release Limits our Liability. Read it!!!

By signing this form, I acknowledge that equine assisted activities is a dangerous activity which may result in injury to me, my horse, or my equipment. With this knowledge, in consideration of the services of Ride On Therapeutic Horsemanship and Therapy Services – RO (Ride On) and as inducement for the services of Ride On to provide equine assisted activities to me, I hereby waive release, discharge and hold harmless Ride On, its officers, directors, employees and volunteer assistants, their heirs, executors, administrators, successors or assigns, from any and all liability for damages sustained by me, my family, any animal owned or controlled by me, or for any item or personalty under my dominion and control. Without limiting the generality for the above, I hereby waive and release Ride On, its officers and directors, employees and all volunteer assistants for liability based on the active or passive negligence of said persons and entities.

I hereby agree to indemnify and hold harmless Ride On, its officers, directors, employees and all volunteer assistants associated therewith for any claims which may be made against them, including attorney’s fees and costs of suit in any action based upon or arising from my acts or omissions, or the actions of any animal within my control.

This release extends to all claims, whether presently known or unknown. I hereby expressly waive any benefits I may have pursuant to Section 1542 of the California Civil Code relating to the release of unknown claims, which provides:

“A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release which if known by him must have materially affected his settlement with the debtor.”

I acknowledge that I have read the foregoing and understand the contents thereof.

Dated: ____________ _________________________________

Dated: ____________ _________________________________ (witness)

MINORS MUST HAVE THE FOLLOWING SIGNED BY THEIR PARENTS OR LEGAL GUARDIANS

I, the undersigned, parent or guardian of ___________________________ ___________________________ for and in consideration of our child’s participation at Ride On Therapeutic Horsemanship state that I have read the waiver, release and hold harmless written above and I expressly agree that the terms and conditions of said waiver, release and hold harmless shall apply to and be binding upon me and my minor child or his or her horse may sustain or cause as a result of said participation. I further warrant I have health and accident insurance for said minor.

Dated: ____________ _________________________________(Parent/Legal Guardian)
Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY and KEEP THIS COPY FOR YOUR RECORDS

Therapy Services – RO is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Therapy Services – RO uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities; fundraising and grant writing and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide schedule reminders, be included in statistics for fundraising, or provide other health related benefits that could be of interest to you.

Therapy Services – RO may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Therapy Services – RO policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Therapy Services – RO may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient’s Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorize by you, when required by law or in emergency circumstances. Therapy Services – RO will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that Therapy Services – RO may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Therapy Director at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Therapy Services – RO health information practices or if you have a complaint, please contact:

Therapy Services at RO – Chatsworth
Gloria Hamblin, Program Director
10860 Topanga Canyon Blvd.
Chatsworth, CA  91311
818.700.2971
gloria@rideon.org
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Patient Information Acknowledgment Form

I have read and fully understand Therapy Services - RO Notice of Information Practices. I understand that Therapy Services - RO may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment, payment or fundraising. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Therapy Services – RO will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Therapy Services - RO Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying Therapy Services – RO in writing at any time.

________________________________________
Patient

____________________________________________________
Signature of Patient, or Patient’s Parent/Guardian if Minor

____________________________________________________
Date
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Payment Agreement

Patient: ________________________________________________________________

Parent/Guardian: ___________________________________________________________

Address: _________________________________________________________________

Email: _____________________________ Phone: _______________________________

I understand that Therapy services cost, on average, $120 per treatment. I intend to assure payment to Therapy Services at Ride On in the following manner:

Required Information

E-check – Checking □ Savings □

Account Number: __________________________________________________________

Routing Number: __________________________________________________________

OR

Credit Card – Master Card / Visa / Amex / Discover

Name on card: _____________________________________________________________

Number: ________________________________________________________________


___ I intend to submit for reimbursement from my medical insurance and will need receipts/superbills. I understand that I am responsible to verify insurance coverage/potential exclusions of coverage with my insurance company directly.

I understand that there is a cost involved in getting staff and horses prepared for each treatment, and realize that I may be charged a $25 fee if I do not show for an appointment and do not call with adequate notice. Exceptions are made for extenuating circumstances, as discussed with the program director or treating therapist. I will notify the therapist or Program Director of any changes in the above information so appropriate arrangements can be made for payment.

______________________________________  ________________________
Signature – patient or parent/guardian                                    date
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**Therapy Services - RO**

- **Chatsworth**
  - 10860 Topanga Canyon Boulevard
  - Chatsworth, California 91311
  - 818.700.2971 ph
  - 805.309.5234 fx

- **Newbury Park/Thousand Oaks**
  - 401 Ronel Court
  - Newbury Park, California 91320
  - 805.375.9078
  - 805.309.5234 fx

**PRESCRIPTION**

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<td>Date:</td>
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<td>Address:</td>
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<td>Date of Birth:</td>
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<td>Diagnosis:</td>
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<td>Date of Onset:</td>
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**PHYSICAL THERAPY**

- □ physical therapy evaluation
- □ physical therapy treatment
- □ other ______________________

**OCCUPATIONAL THERAPY**

- □ occupational therapy evaluation
- □ occupational therapy treatment
- □ other ______________________

**SPEECH/LANGUAGE THERAPY**

- □ speech/language therapy evaluation
- □ speech/language therapy treatment
- □ other ______________________

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<td>Frequency:</td>
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<td>Duration:</td>
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<td>□ 1 year</td>
<td>____________________</td>
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<tr>
<td>□ other</td>
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<td>Precautions/Comments:</td>
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**PLEASE PRINT**

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<td>MD DO NP PA other</td>
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<td>Signature:</td>
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<td>License/UPIN Number:</td>
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<td>Email:</td>
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Information on annual family income is required to determine client eligibility for certain services funded by the City of Los Angeles through the Community Development Block Grant Program. Please fill out the form below and find the row with the number of persons in your family and circle the family income range appropriate for you. We treat this information with complete confidentiality.

<table>
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<tr>
<th>First Name</th>
<th>Last Name</th>
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<tr>
<th>Address</th>
<th>Apt. #</th>
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<thead>
<tr>
<th>Phone #</th>
<th>Birthdate</th>
<th>Gender</th>
<th>Rider Name:</th>
<th>Date:</th>
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Please Check All That Apply

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<tr>
<th>Disability</th>
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<th>Customer Family Type</th>
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- Disabled Adult (16 and Over)
- Disabled Child (15 and Under)
- None

- 0 - 8th Grade
- 9 - 12th Grade
- 2 or 4 Year College Degree
- High School Grad / GED

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<tr>
<th>Race (please check one of the following categories)</th>
<th>Ethnicity (check one)</th>
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- American Indian or Alaskan
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White (not Hispanic or Latino)

- Asian AND White
- Black or African American AND White
- American Indian AND Black/African American
- Balance/Other

- Hispanic/Latino
- Not Hispanic /Latino

2019 CDBG Income Guidelines (Circle one)

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<tr>
<th>Family Size</th>
<th>B: Income</th>
<th>C: Income</th>
<th>D: Income</th>
<th>E: Income</th>
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<tbody>
<tr>
<td>1 Person</td>
<td>$0 - $21,950</td>
<td>$21,951 - $36,550</td>
<td>$36,551 - $58,450</td>
<td>$58,451 +</td>
</tr>
<tr>
<td>2 Persons</td>
<td>$0 - $25,050</td>
<td>$25,051 - $41,800</td>
<td>$41,801 - $66,800</td>
<td>$66,801 +</td>
</tr>
<tr>
<td>3 Persons</td>
<td>$0 - $28,200</td>
<td>$28,201 - $47,00</td>
<td>$47,001 - $75,150</td>
<td>$75,151 +</td>
</tr>
<tr>
<td>4 Persons</td>
<td>$0 - $31,300</td>
<td>$31,301 - $52,200</td>
<td>$52,201 - $83,500</td>
<td>$83,501 +</td>
</tr>
<tr>
<td>5 Persons</td>
<td>$0 - $33,850</td>
<td>$33,851 - $56,400</td>
<td>$56,401 - $90,200</td>
<td>$90,201 +</td>
</tr>
<tr>
<td>6 Persons</td>
<td>$0 - $36,350</td>
<td>$36,351 - $60,600</td>
<td>$60,601 - $96,900</td>
<td>$96,901 +</td>
</tr>
<tr>
<td>7 Persons</td>
<td>$0 - $38,850</td>
<td>$38,851 - $64,750</td>
<td>$64,751 - $103,550</td>
<td>$103,551 +</td>
</tr>
<tr>
<td>8 Persons</td>
<td>$0 - $41,350</td>
<td>$41,351 - $68,950</td>
<td>$68,951 - $110,250</td>
<td>$110,251 +</td>
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Ride On gives over 1,700 Scholarship lessons and treatments per year. The income and ethnicity information above is critical when we pursue funding sources, seek support for scholarships and to determine eligibility for public services funded by the City of Los Angeles. I certify that the information on this form is accurate and complete.

Signature (parent if needed): ___________________________ Rider Name: ___________________________ Date: ___________________________

Address: ____________________________________________

Ride On Staff: ___________________________ Signature: ___________________________ Date: ___________________________