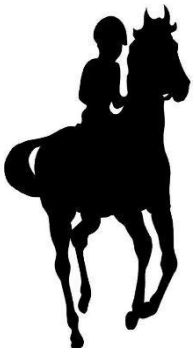

Back In The Saddle Equine Therapy Center

PO Box 325, Hopkinton, NH 03229
phone: (603) 456-2761 fax: (603) 456-2766
Tax ID: 20-0652400
info@bitsetc.org www.bitsetc.org

CLIENT REGISTRATION PACKET

Hello to all BITS ETC Participants,

Thank you for your interest in our programs. We schedule lessons Monday through Saturday. Please fill out this application form completely and indicate the program you wish to pursue. Once completed, you may reserve your lesson time with the instructor. Lessons will be billed at the end of each month and due upon receipt. We accept cash, check (made payable to BITS ETC) or Venmo (@BITSETC). Your prompt payment is appreciated. Should a client have two outstanding invoices, lessons will be put on hold until the account is paid in full.

Pages 1 through 4 are for your information – please keep them for reference.

Pages 7, 8 and 9 of the application for riding should be removed and given to your doctor for him/her to return to BITS ETC. These forms may be faxed to our secure fax by the MD's office.

Should you need to cancel a lesson we ask that you contact your instructor directly. You'll find your instructor's contact information on page 2 as well as our attendance policy. Missed lessons without notice will be forfeited. For weather above 85 degrees, or below 20 degrees, lessons may be cancelled, or changed to unmounted lessons. If this occurs, your instructor will contact you in regard to the lesson. Any snow days in which Hopkinton schools are cancelled BITS will be closed. We will notify you of other times if lessons must be cancelled or rescheduled.

I look forward to seeing you all "back in the saddle!"

Best Regards,

Jaryn Hall-Haines
Executive Director

BITS ETC CONTACT NUMBERS

Office & Barn Number: (603) 456-2761

E mail: info@bitsetc.org

Office Secure Fax: (603) 456-2766

Executive Director: Jaryn Hall-Haines (603) 545-5886

Melissa LoVetere, Admin/Lead Instructor: (978) 886-0392
(not case sensitive) MelissaL@bitsetc.org

PATH certified therapeutic riding instructor offering Therapeutic Riding, Vocational Education, Equine Assisted Learning, Ride UP for Uniformed Professionals, and Balanced Seat

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Kathy Mauzerall, Instructor: (603) 344-8848
(not case sensitive) ktymzrl@gmail.com

Hippotherapy certified instructor offering Therapeutic Riding and Ride UP for Uniformed Professionals

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BITS ETC General Information

BITS ETC offers therapeutic riding, vocational education, and equine assisted learning Monday through Saturday, year-round. Please note your instructor's name and contact information on our contact sheet

- Lessons are reserved by completing the application packet and scheduled with the instructor.

- On-going lessons may be maintained with payment of monthly invoices, sent at the end of each month.

- Snow policy: If Hopkinton NH schools are closed, BITS is closed.

- At the instructor's discretion, if it is hotter than 85 degrees, or colder than 20 degrees, astride lessons will be replaced with equine centered activities held in the classroom, or unmounted activities in the barn.

- Make up lessons will be offered as needed for excused lessons missed each month.

- For the safety of riders and our horses, a weight limit is set for each horse. We offer ground work lessons and equine assisted activities for those who do not currently meet the guidelines.

Class Attendance Policy

Thank you for choosing BITS ETC!

We schedule lessons by the month. Many people are involved in providing safe lessons: leaders, side walkers and your instructor. Your time and our time are valuable. Your lessons begin with completed paperwork, including MD clearance to ride. Once completed we will schedule your lessons on a particular day and time that works for all. Invoices will be sent out following the month's lessons. Should you need to reschedule lessons for a different day or time, or schedule time off from lessons, please contact your instructor. Lessons cancelled by BITS, and **excused** absences may be made up.

Excused Absence:

- Excused absences are those resulting from emergency, illness, or accident of rider or a family member.
- Doctor appointments, vacations or other explained absences (sporting events, school events, etc.) *with advanced notice.* Advanced notice is considered one week notice for vacations, appointments or other explained absence and a minimum of two hours prior to lesson for illness/accident.

Unexcused Absences:

- Lesson is missed with no communication to instructors (No call/No show).
- Lessons missed for reasons not related to disability, illness or injury.

Late Policy:

Lessons are scheduled in ½ hour, 1 hour and 2-hour blocks. If you are late for your lesson, you may still participate but it will only be for your regularly scheduled time slot. For example: Lesson time is 1pm-2pm and you arrive at 1:20pm. Your lesson will run from 1:20pm-2pm.

If you are too late to ride during the time remaining, (i.e. less than 20 minutes) you may have a 'ground lesson' of interaction with your horse for the remainder of time reserved for that lesson.

We look forward to getting you 'back in the saddle!' See you soon.

BITS
BACK IN THE SADDLE
ETC
EQUINE THERAPY CENTER
www.bitsetc.org • 603-456-2761

REGISTRATION FORM

Participant Name_____

Primary Contact_____Phone_____

Address [street]_____ [city/zip] _____

E-Mail [please print clearly] _____

Age_____ Height_____ Weight_____

I wish to register for the following program:

_____Therapeutic Riding
_____Equine Assisted Learning (EAL)
_____Vocational Education
_____RideUP Program
_____StepUP Program
_____SOAR Program

I understand that when all required paperwork has been received (medical clearances) BITS ETC shall contact me to schedule a preliminary visit to establish suitability and schedules.

PHOTO RELEASE

I ❑ DO ❑ **DO NOT** consent and authorize the taking and use / reproduction of any and all photographs, and or other audiovisual materials taken of me by BITS ETC for promotional, (printed, or web-based), exhibitions, educational activities, or for any other use for the benefit of BITS ETC.

_____ _____
Signature (Parent or Guardian if under 18) date

❑ I DO ❑ **DO NOT** wish to receive emails regarding upcoming events, announcements, fundraisers, etc.

Help us to learn a little more about you.
This will assist our instructors to better tailor your experience with us.

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

_____
_____
_____

Previous Experience (have you ridden before, or had experiences with horses?)

_____
_____

Physical Function (mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____
_____
_____

Psycho/Social Function (Work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.):

_____
_____
_____

Learning Style (How do you, or your child, learn best? Watching someone show you, listening to an explanation, doing the activities matching your body to the instructor's, or figuring something out on your own.)

_____
_____
_____

Have there been any past surgeries? Are there any limitations or restrictions regarding movement or activity?

_____
_____
_____

Allergies: _____

Is there a crisis plan for the participant? If so, please provide details.

_____
_____
_____

Other things you would like to share with us

_____
_____
_____

Dear Healthcare Provider:

Your patient: _____ DOB_____
(Participant's Name: **PLEASE PRINT**)

Is interested in participating in supervised equine 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.

Orthopedic Medical/Psychological Atlantoaxial Instability-include neurologic
Allergies
Symptoms Animal Abuse
Coxa Arthrosis Cardiac Condition
Cranial Deficits Physical/Sexual/Emotional Abuse Heterotopic Ossification/Myositis Ossificans
Blood Pressure Control
Joint subluxation/dislocation Dangerous to self or others Osteoporosis Exacerbations of medical conditions
(RA, MS) Pathologic Fractures Fire Settings
Spinal Joint Fusion/Fixation Hemophilia
Spinal Joint Instability/Abnormality Medical Instability
Migraines

Neurologic PVD
Hydrocephalus/Shunt Respiratory Compromise
Seizure Recent Surgeries
Spina Bifida/Chiari II malformation Substance Abuse
Tethered Cord/Hydromyelia Thought Control Disorders

Other
Age under 4 years
Indwelling Catheters/Medical Equipment
Medications side-effects i.e. photosensitivity, fatigue
Poor Endurance
Skin breakdown (decubitus ulcers, etc.)

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 BITS ETC at the above address/phone number.

PARTICIPANT MEDICAL HISTORY AND PHYSICIAN STATEMENT

Participant _____DOB_____Height_____Weight_____
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 _____
Mobility: (circle one) Independent Ambulation Assisted Ambulation Wheelchair

Braces/Assistive Devices_____
For those with Down's syndrome: AtlantoDens Interval X-Rays done _____ Result: _____
Neurologic Symptoms of Atlanto-Axial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries. If "Yes," please explain.

	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 activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to BITS ETC for on-going evaluation to determine eligibility for participation.

Name _____MD DO NP PA Other_____

Signature_____ Date_____

Address_____

Phone ( )_____NPI #_____

PARTICIPANT CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ **Phone #**_____
(*Healthcare Provider, School, Other Party:* **PLEASE PRINT)**

To share protected personal information with Back In The Saddle Equine Therapy 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
- Occupational 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.

Name [please print] _____Phone _____

Relationship to Participant_____

Signature_____Date_____
(**Parent or Guardian if under 18**)

Please fax information to Back In The Saddle Equine Therapy Center at secure fax# (603) 746-3522, or mail to PO Box 325, Hopkinton, NH 03229

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name _____DOB_____

Address [street]_____[city/zip]_____

Phone [home]_____[cell]_____Email _____

Physician's Name_____Phone_____

Allergies to medications? _____

Current Medications_____

In the event of an emergency, contact:

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

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

Date _____ Consent signature_____

(Parent or Legal Guardian if under 18)

RELEASE OF LIABILITY

Although every effort will be made to avoid accident or injury, NO LIABILITY can be accepted by BITS ETC, it's officers, board of directors, agents, employees, and any of its members, associates, or the property owners upon whose land the therapeutic riding sessions are conducted.

According to RSA 508:19:

"…an equine activity sponsor, an equine professional, or any other person engaged in an equine activity, shall not be liable for any injury or the death of a participant resulting from the inherent risks of equine activities and, except as provided in paragraph III of this section, no participant's representative shall made any claim against, maintain an action against, or recover from any other person for injury, loss, damage, or death of a participant resulting from any other inherent risks of equine activities. Each participant in an equine activity expressly assumes the risk of and legal responsibility for any injury, loss or damage to person or property which results from participation in an equine activity. Each participant shall have the sole responsibility for knowing the range of his or her ability to manage, care for, and control a particular equine or perform a particular equine activity, and it shall be the duty of each participant to act within the limits of the participant's own ability, to maintain reasonable control of the particular equine at all times while participating in an equine activity, to heed all posted warnings, and to refrain from acting in a manner which may cause or contribute to the injury of any person…"

I have read and understand the legal limits of liability of BITS ETC, and request to participate in therapeutic riding activities as a (**please initial**):

_____Client _____one- time Visitor/Clinic Participant

I understand the inherent risks and potential for risk of equine activities, and agree to accept them. I hereby, intending to be legally bound for myself, my heirs, and assigns, executors, and administrators, waive and release forever all claims for damages against BITS ETC, its board of directors, instructors, therapists, aides, volunteers, and /or employees for any and all injuries and or losses I (my child, ward) may sustain while participating in the Program from whatever cause including but not limited to the negligence of these released parties. The undersigned acknowledges that he / she has read this Liability Release in its entirely; that he / she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.'

_____ _____

Participant [**Please print clearly**] Date

_____ _____

Signature (Parent or Guardian if under 18 years old) Date

CONFIDENTIALITY POLICY

It is the policy of Back In The Saddle Equine Therapy Center to hold absolutely confidential all charts, and communications (oral or written) made by and between or about Therapeutic Riding Center staff, board, volunteers, and clients. It is required that all staff, board members, and volunteers sign this confidentiality agreement. All of these persons are accountable for maintaining the confidentiality of therapy which occurs at BITS ETC. BITS ETC shall treat all communications regarding therapy as protected health information and will be guided by the Federal Health Insurance Portability and Accountability Act (HIPAA) in all dealings with outside agencies or interested persons.

Confidential Communication is any information that is either written or spoken, and shared between client, and / or family-guardian, and staff, volunteers, and board of directors in the course of service delivery of Equine Assisted Therapy and Equine Assisted Learning activities at BITS ETC. The information that is exchanged is considered confidential and is to be kept as such by all involved, and disclosed only to those people who are:

1. Present at the time the information is shared and working to further the interests of the client.
2. Working for BITS ETC, maintaining records of clients for informational purposes (i.e.) to aid in evaluation, and facilitating communications between staff/ volunteers, as well as for medical and psychological documentation.
3. Not associated with BITS ETC, but working on behalf of the client, such as an attorney, counselor, housing worker, or other social service agent.

Maintenance of Records:

1. BITS ETC maintains all records in a strictly confidential manner. Only staff members have access to these records. Clients/guardians may access their records at any time, and copies are available for a nominal copying fee.
2. In cases where information must be disclosed to others, BITS ETC must have a signed release form on file from the client or guardian before said information is disclosed.

(over for signature)

CONFIDENTIALITY POLICY (continued)

Exceptions for the Release of Information:

1. Where a staff member or volunteer has reason to suspect a person has been either physically or sexually abused, a report must be made to the appropriate authority. If a volunteer suspects abuse, they should notify a staff member who will be responsible for reporting such. If the client is willing to report the abuse themselves, BITS ETC will have complied with the requirements for reporting. If they assist that individual with making the report.
2. In criminal proceedings, when the court has determined, through the procedure explained in RSA 173-c, that the information contained in the record or testimony is admissible under chapter 173-c, where medical emergency exists and the information from the file is required and the client/family/guardian is unable to authorize the release, information limited to the medical emergency will be **disclosed to any emergency personnel, and / or the medical institution treating the client.**

I [**please print name**]**_____**
have read and agree to abide by the confidentiality policy of BITS ETC.

_____ _____
Signature (Parent or Guardian if under 18 years old) Date