Wild Hearts Equine Therapeutic Center, Inc.

135 Jim Joe Road, Seneca, SC 29678
www.wildheartsequinetherapy.org
864-991-9163

Dear Prospective Participant and Family,

Wild Hearts Equine Therapeutic Center, Inc., also known as Wild Hearts Equine Therapy Center is a 501(c)(3) non-profit company that cultivates powerful connections between people and horses through innovative and customized equine-assisted learning and therapeutic riding programs. Our therapy models include:

- Therapeutic riding following traditional PATH methodology
- The methods of Equine Assisted Growth and Learning Association (EAGALA)
- Natural Lifemanship: Trauma-Focused Equine Assisted Psychotherapy (TF-EAP™)
- Non-traditional forms of equine therapy as required

It is our mission to provide a safe and compassionate environment that fosters physical, emotional and behavioral growth utilizing programs that enrich the quality of life for people of all ages.

Our programs go beyond typical riding and horsemanship lessons. Understanding the language and behavior of the horse, as well as evaluating the ability and readiness of the horse and the human to take the next step, is an integral part of all of our programs.

If you are interested in becoming a participant in our program, please complete the enclosed application and return them to Wild Hearts Equine Therapeutic Center, Inc. at the address listed above.

Thank you for your interest in Wild Hearts Equine Therapeutic Center, Inc.! Please feel free to contact us with any questions. We look forward to hearing from you soon.

Sincerely,
Jessica Fry, Founder
Wild Hearts Equine Therapeutic Center, Inc.

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APPLICATION PROCESS AND PARTICIPATION POLICY

Business Hours: 8am – 6pm (email anytime)

Age Requirement: The minimum age to participate in our program is 4 years old. There is no upper age restriction to be involved.

Weight Requirement: In order to participate in the Wild Hearts Equine Therapeutic Center Riding Program, there is a rider weight limit of 20% of horse weight, up to 220 pounds, depending which horse is utilized, as well as the physical health and stability of the horse.

Application Process: To begin the application process, please sign and return the following forms:

- Safety Agreement and Liability Release for anyone who accompanies participant
- Participant Application
- Authorization for Emergency Medical Treatment
- Participant Medical History and Physician's Statement
- Release of Information Form

Please note that the Medical History and Physician's Statement **MUST** be signed by your medical provider. You will be responsible for providing Wild Hearts Equine Therapeutic Center, Inc. with an updated medical form **ANNUALLY**, in addition to notifying us of any medical changes that should occur during the year.

Once we receive and review the completed forms, we will contact you to set up an evaluation. Every new client and his/her family meets with an instructor for a one-hour evaluation during which you meet your instructors and discuss historical information and goals. If appropriate, a portion of the one-hour evaluation will be mounted.

Scheduling: Wild Hearts Equine Therapeutic Center, Inc. offers individual sessions on a weekly basis year round. Session content will be determined based on the specific needs and goals of the individual. Sessions are scheduled for 50 minutes, but may conclude early depending on client needs. The appropriate number of volunteers for each client will be determined on a case by case basis.

Attendance: We have a 24-hour cancellation policy so that staff and volunteers may be notified. Cancellations due to unforeseen emergencies will not be billed. The first no-show cancellation is free. After that, $20 per no show session will be billed. Client will be subject to dismissal after three no-show appointments.

Weather Cancellations: In the case of inclement weather, Wild Hearts will coordinate with client family to determine the best course of action. Session may be canceled up to one hour prior to session time. In the case that resources allow, we may reschedule the session.

Arrival Time: Participants should arrive at Wild Hearts approximately 10 minutes prior to session time and be prepared to start on time, as sessions will end on time to allow for the next participant to start on time. If you are late, the session will end as scheduled out of respect for other participants, staff and volunteers. If you are early, sessions will not last more than 50 minutes.

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APPLICATION PROCESS AND PARTICIPATION POLICY, CONTINUED

Attire: For those participating in our riding program, jeans or leggings are required. Shorts are allowed in extremely hot conditions. Closed-toed shoes (boots with a heel are preferred but tennis shoes are allowed) and an ASTM approved riding helmet are required. No sweatpants, athletic or nylon pants are permitted. No crop tops or mid-drifts allowed.

Session Prices: $40.00/session. Payment is required at time of service unless services are provided free of charge or billed through insurance by your professional counselor.

Sessions: It is common for Wild Hearts facilitators to spend several sessions teaching horsemanship, while allowing clients to bond with horses. As such, clients may not ride a horse during their first few sessions. Equine-guided sessions may sometimes include unmounted activities. This time will include grooming, tacking, feeding, and other tasks. All sessions are the same price, whether mounted or unmounted.

Safety: Safety is paramount at Wild Hearts. ALL family members and other observers must abide by safety rules and sign a safety agreement, as well as a liability waiver. For the safety of our students, volunteers and staff, treats will only be given to the horses as per discretion of the instructor. Hand feeding is not permitted.

Other: An ADA-compliant restroom is provided for your convenience. Please remember to thank our volunteers; they give their time freely so that you/your child can participate in the program.

STATEMENT OF PARTICIPANT ELIGIBILTY OR DISMISSAL

Wild Hearts Equine Therapeutic Center, Inc. offers services to both students with special needs and typically developing students. Eligibility for participation in our programs is based solely upon an individual's ability to participate meaningfully and safely, provided the necessary resources are available. This may include an instructor, horse and the assistance of a leader and a side walker during each adaptive riding session to ensure the safety of each student, as well as proper positioning. Financial information is not taken into account when determining an individual's eligibility for participation.

Wild Hearts Equine Therapeutic Center, Inc. reserves the right to determine the ability to accept an applicant due to the availability of resource(s) and/or safety concerns.

Wild Hearts Equine Therapeutic Center, Inc. reserves the right to discontinue the participation of an individual in its programs when it is deemed in the best interest of Wild Hearts Equine Therapeutic Center, Inc. and/or the individual involved.

ACKNOWLEGEMENT OF PROCESS AND PARTICIPANT POLICY

I have read and acknowledge the process and policies set forth above.

_____ Date: _____

Signature (Client, Parent, Legal Guardian)

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PARTICIPANT APPLICATION

Participant Name: _____ DOB: _____

Age: _____ Height: _____ Weight: _____

Address:

_____

Home Phone: _____ Cell Phone: _____

Email: _____

Employer/School: _____

Parent/Legal Guardian: _____

Address (if different from above):

_____

Phone (if different from above): _____ Email: _____

In the event of an emergency, please contact:

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Physician's Name: _____ Telephone: _____

Preferred Medical Facility: _____

Health Insurance Carrier: _____ Plan/Policy No: _____

Existing Medical Conditions/Disability/Diagnosis: _____

_____

_____

How did you hear about our program(s)?

_____

_____

Which program(s) are you interested in participating? (check one)

_____ Therapy Riding Lessons _____ Unmounted Horsemanship EAGALA _____

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HEALTH HISTORY – ***Please indicate current or past special needs in the following areas****:*

	Y	N	Comments
Mobility			
Vision			
Hearing			
Sensation			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Shunt			**Last Revision:**
Seizures			**Last Seizure:**

MEDICATIONS (include prescription and over-the counter, name, dose, frequency)

_____

_____

Describe abilities/difficulties in the following areas (include assistance/equipment required):

PHYSICAL FUNCTION (e.g. mobility skills such as walking, transfers, wheelchair use, driving/bus riding, etc.)

_____

_____

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

_____

_____

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GOALS: Why are you applying? What would you like to accomplish?

_____

_____

_____

_____

_____

_____ Date: _____

Signature (Client, Parent, Legal Guardian)

MEDIA RELEASE (OPTIONAL):

I DO HEREBY CONSENT to and authorize the use and reproduction by Wild Hearts Equine Therapeutic Center, 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 program(s).

_____ Date: _____

Signature (Client, Parent, Legal Guardian)

Code of Laws of South Carolina 1976 Annotated. Title 47. Animals, Livestock and Poultry. Chapter 9. Livestock Generally. Article 7. Equine Liability Immunity.

Under South Carolina law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity, pursuant to Article 7, Chapter 9 of Title 47, Code of Laws of South Carolina, 1976.

LIABILITY RELEASE: The above named person would like to participate in Wild Hearts Equine Therapeutic Center, Inc.'s program (s). I/my child fully understand and acknowledge that risks and dangers exist in horseback riding and working with horses, and my/my child's participation in such activities may result in my/my child's injury or illness, including grievous bodily harm. However, I feel the possible benefits to myself/my child are greater than the risks assumed. I hereby, intending to be legally bound for myself /my child, my heirs and assigns, executors or administrators, voluntarily waive, discharge, hold harmless, and release forever all claims for damages against Wild Hearts Equine Therapeutic Center, Inc., its Founder, Board Members, Instructors, Volunteers and /or Employees for any and all injuries and/or losses I/my child may sustain while participating at Wild Hearts Equine Therapeutic Center, Inc. from whatever cause, including but not limited to the negligence of these related parties.

THE UNDERSIGNED ACKNOWLEDGES THAT THEY HAVE READ THIS APPLICATION IN ITS ENTIRETY; THAT THEY UNDERSTAND THE TERMS OF THIS RELEASE AND HAS SIGNED THIS RELEASE VOLUNTARILY AND WITH FULL KNOWLEDGE OF THE EFFECTS THEREOF.

_____ Date: _____

Signature (Client, Parent, Legal Guardian)

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 Wild Hearts Equine Therapeutic Center, Inc. to:

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

Client's Name: _____

Phone: _____

Street Address: _____

City, State and Zip: _____

In the event I cannot be reached:

Contact 1: _____ Phone: _____

Contact 2: _____ Phone: _____

Consent Plan

This authorization includes, but is not limited to x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person above is unable to be reached.

_____ Date: _____

Signature (Client, Parent, 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: _____

Signature (Client, Parent, Legal Guardian)

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Date: _____

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities conducted at Wild Hearts Equine Therapeutic Center, Inc.

In order to safely provide this service, our program requests that you complete/update the enclosed Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions or contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Neurologic

- ☐ Hydrocephalus/Shunt
- ☐ Seizure
- ☐ Spina Bifida/Chiari II Malformation/ Tethered Cord/Hydromyelia

Orthopedic

- ☐ Atlantoaxial Instability -include neurologic symptoms
- ☐ Coxarthrosis
- ☐ Cranial Defects
- ☐ Heterotopic Ossifications/Myositis Ossificans
- ☐ Joint Subluxation/Dislocation
- ☐ Osteoporosis
- ☐ Pathologic Fractures
- ☐ Spinal Joint Fusion/Fixation
- ☐ Spinal Joint Instability/Abnormalities

Medical/Psychological

- ☐ Allergies
- ☐ Animal Abuse
- ☐ Cardiac Condition
- ☐ Physical/Sexual/Emotional Abuse
- ☐ Blood Pressure Control
- ☐ Danger to Self or Others
- ☐ Exacerbations of Medical Conditions (e.g. RA, MS)
- ☐ Fire Setting
- ☐ Hemophilia
- ☐ Medical Instability
- ☐ Migraines
- ☐ PVD
- ☐ Respiratory Compromise
- ☐ Recent Surgeries
- ☐ Substance Abuse
- ☐ Thought Control Disorders
- ☐ Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact our program.

Sincerely,
Jessica Fry, Founder
Wild Hearts Equine Therapeutic Center, Inc.
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PARTICIPANT MEDICAL HISTORY AND PHYSICIAN STATEMENT

Name: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____

Date of Onset: _____

Past/Prospective Surgeries: _____

_____

_____

Medications: _____

_____

_____

Seizures? (Circle One) Y N Type: _____ Controlled? (Circle One) Y N

Date of Last Seizure: _____

Shunt Present? (Circle One) Y N Date of Last Revision: _____

Special Precautions (Diet/Needs/Allergies): _____

_____

_____

Participation: (Check One)

_____ May participate in all activities.

_____ May participate in all activities except for: _____

Mobility: (Check One)

- ❑ Independent Ambulation
- ❑ Assisted Ambulation
- ❑ Wheelchair

Braces/Assistive Devices: _____

_____

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SPECIAL NEEDS

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

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

*For those with Down Syndrome: AtlantoDens Interval X-rays Date: _____ Result: + -

Neurological Symptoms of AtlantoAxial Instability: _____

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IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:

If you prefer to provide the requested information on your own medical form, we will accept that form as long as the top and bottom sections of this form are also completed, signed, dated and stapled to your form.

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine activities. I understand that the adaptive riding program will weigh the medical information above against existing precautions and contraindications. Therefore, I refer this person to the program for ongoing evaluation to determine eligibility for participation.

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

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

Stamp:

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HIPAA RELEASE OF INFORMATION

I, _____(client name) hereby authorize _____ (physician name) and its affiliates, its employees and agents, collectively _____ (practice name), to release to Wild Hearts Equine Therapeutic Center, Inc. personal health information (e.g., information relating to the diagnosis, treatment, billing and health care services provided or to be provided and which identifies personal name, address, social security number, Member ID number) of _____(client name) maintained by _____ (physician name).

I understand that any personal health information or other information released to Wild Hearts Equine Therapeutic Center, Inc. may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall remain in force as long as _____ (client name) is a participant at Wild Hearts Equine Therapeutic Center, Inc.

I understand that I have a right to revoke this authorization by providing written notice to _____ (physician name). However, this authorization may not be revoked if _____ (physician name), its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Participant/Parent/Legal Guardian: _____

Signature of Participant/Parent/Legal Guardian: _____

Date:_____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Participant identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Participant's behalf with respect to this authorization form.

_____	_____
Name of Legal Representative	Name of Witness
_____	_____
Signature of Legal Representative	Signature of Witness
_____	_____
Date	Date