



Dear Rider/Parent:

Thank you for your interest in Stajduhar Stables Equine Assisted Therapy Programs. This information is intended to help you understand the application paperwork you are receiving. Please understand that this paperwork is necessary for Stajduhar Stables to be in compliance with our accreditation standards and insurance obligations.

- **Patient Registration Form**
- **Consent/Non-Consent for Emergency Medical Treatment**
- **Rider's Medical History and Physician's Statement – completed by M.D.**
- **Release of Liability**
- **Photo Release/Non-Consent**

Hippotherapy is offered Monday through Friday from 9:00AM to 7:00PM. Hippotherapy is clinical physical, occupational, or speech language pathology using the horse as a treatment tool and is administered by licensed physical, occupational, or speech language pathologists. A NARHA therapeutic riding instructor is also present. **A physician's prescription for physical, occupational, or speech language pathology is required.** Hippotherapy fees are determined by the procedures administered.

During your first appointment, based on the physician's referral the physical, occupational or speech language pathologist will perform an initial evaluation, identify patient impairments or problems, set short term and long term goals and identify treatment activities to meet the goals. The treatment plan will be discussed with the patient and family. A clinical chart will be maintained by all rehab personnel treating each client.

For your convenience, your insurance coverage will be verified prior to your first treatment session. Where appropriate, Stajduhar Stables will bill your insurance company as a courtesy to you. All other fees and co-pays will be due at the time services are rendered. For your convenience, MasterCard and Visa are accepted.

Therapeutic riding sessions are offered Monday through Friday from 9:00AM to 7:00PM. Therapeutic riding uses equine oriented activities for the purpose of contributing positively to the cognitive, physical, emotional, and social well-being of people with disabilities. Therapeutic riding provides benefits in the areas of education, sport, recreation, and leisure. Therapeutic riding instructors are responsible for the program. The rehabilitation staff is involved on a consultative basis as needed.

Because Therapeutic riding is not a covered benefit by most insurance companies, the fee schedule is as follows. Private lessons are \$35.00 for a 30 minute lesson. One hour lessons are \$70.00. Payment is due at the time services are rendered. Checks, cash, and credit card payments are accepted.

To be in compliance with national standards, we have established the following criteria for participation in Hippotherapy and therapeutic riding:

- Age – the minimum age for hippotherapy is 2 years old and the minimum age for therapeutic riding is 4 years old
- Cognitive ability – Hippotherapy and therapeutic riding can be successful with behavioral problems and all adult patients should be able to follow simple directions.
- Height and Weight – As a general rule, the horse should not carry more than 20% of its body weight. The following rider weight guidelines have been established:
  - Under 5' tall – 150 lbs.
  - 5' – 5'6" tall – 175 lbs.
  - 5'6 – 6' tall – 200 lbs.
  - 6'1" – 6'5" tall – 260 lbs.

Please complete the enclosed forms and fax, mail, or bring these forms to Stajduhar Stables prior to your first appointment. Our phone number is **(817) 849-1999** and fax number is **(817) 503-8130**. If you have any questions, please do not hesitate to call me. We look forward to helping you achieve your physical, speech and occupational therapy needs.

Sincerely,

Lisa Stajduhar, MMSc, PT  
Stajduhar Physical Therapy  
Advanced Therapeutic Riding Instructor  
Registered Hippotherapist

**PATIENT REGISTRATION FORM**  
**PLEASE PRINT**

**PATIENT INFORMATION**

CODE:	REFERRING MD:
NAME- LAST, FIRST:	ACCIDENT-Y/N:
ADDRESS:	EMPLOYMENT- FT/PT/UN- EMPLOYED:
CITY:	MARITAL STATUS - S, M, D:
STATE/ZIP:	STUDENT - Y, N:
HOME PHONE:	SEX:
WORK PHONE:	BIRTHDATE:
SSN#:	ONSET OF PROBLEM:
PATIENT'S EMPLOYER:	PRIOR P.T. RX THIS YEAR?
ADDRESS:	
CITY:	STATE/ZIP:
WORK PHONE:	
<b>RESPONSIBLE PARTY (IF OTHER THAN SELF)</b>	
NAME- LAST, FIRST:	HOME ADDRESS:
EMPLOYER:	SSN#:
ADDRESS:	BIRTHDATE:
CITY:	TX DRIVER'S LICENSE NUMBER:
STATE/ZIP:	WORK PHONE:
<b>INSURED INFORMATION</b>	
INSURED'S NAME- LAST/FIRST:	SEX:
INSURANCE CO. NAME:	SSN#:
ADDRESS:	BIRTHDATE:
CITY:	RELATIONSHIP TO PATIENT:
STATE/ZIP:	INS. PHONE:
GROUP/PLAN #:	ADJUSTER'S PHONE:

**Authorization and Agreements for Treatment and Payment**

1. I HEREBY AUTHORIZE STAJDUHAR PHYSICAL THERAPY TO RENDER TREATMENT AT MY PHYSICIANS REQUEST OR APPROVAL.
2. RELEASE OF MEDICAL INFORMATION-I HEREBY AUTHORIZE THE CLINIC TO RELEASE ANY MEDICAL INFORMATION IN CONNECTION WITH THESE SERVICES RENDERED TO MYSELF OR MY DEPENDENTS TO ANY OR ALL OF THE FOLLOWING:  
a) Health Insurance Companies, b)Automobile Insurance, c)Attorney, d)Patient's employer in the event of a Worker's Compensation Injury.
3. FOR AND IN CONSIDERATION OF CARE AND TREATMENT PROVIDED TO THE PATIENT, I WILL PAY THE CLINIC FOR ALL CHARGES AND SERVICES RENDERED TO OR ON BEHALF OF THE PATIENT WHICH ARE NOT COVERED BY THE INSURANCE PAYMENT. IT IS OUR POLICY TO BILL YOUR INSURANCE CARRIER AS A COURTESY TO YOU AFTER VERIFICATION OF INSURANCE HAS BEEN MADE. I WILL PAY MY ESTIMATED PERCENTAGE AT THE TIME SERVICES ARE RENDERED. If my insurance company does not remit payment within 45 days, the balance due will be paid by me. I will receive monthly statements if my account has a balance due regardless of any claim pending between ME and the INSURANCE COMPANY.
4. I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO STAJDUHAR PHYSICAL THERAPY. (A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL).
5. I UNDERSTAND THAT STAJDUHAR PHYSICAL THERAPY IS NOT A MEDICARE PROVIDER AND THAT I WILL BE RESPONSIBLE FOR THE BILL IF I AM A MEDICARE PATIENT.

I HAVE READ AND FULLY UNDERSTAND THE ACKNOWLEDGMENTS AND AGREEMENTS.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

LEGAL GUARDIAN/INSURED'S  
SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Method of Payment ( ) cash/check ( ) work comp ( ) insurance

**\$15.00 charge on all returned checks**

## RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Parent: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Onset: Birth Childhood Adolescent Adult  
(Circle One)

**For Persons with Down Syndrome: Because of the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for atlantoaxial dislocation condition.**

**Cervical x-ray for Atlantoaxial instability: Positive \_\_\_\_\_ Negative \_\_\_\_\_ Date of X-Ray: \_\_\_\_\_**

**Results of annual cervical exam for symptoms of AAI: Positive \_\_\_\_\_ Negative \_\_\_\_\_ Date \_\_\_\_\_**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Tetanus Short:  Yes  No Date: \_\_\_\_\_

Current Medications: \_\_\_\_\_

For: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please explain:

Areas	Yes	No	Explanation
Auditory			
Visual			
Vision without correction			
Vision corrected to			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Other			

(Please see other side for required signatures)

**RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT (page 2)**

Rider's Name: \_\_\_\_\_

Mobility: Ambulation  Yes  No Wheelchair  Yes  No Crutches  Yes  No Braces  Yes  No

Please indicate any special precautions: \_\_\_\_\_

**Information for Physician**

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether conditions are present, and to what degree:

Orthopedic

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Atlantoaxial Instabilities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation and Dislocation
- Osteoporosis
- Pathologic Fractures
- Coxas Arthrosis
- Heterotopic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses
- Internal Spinal Stabilization

Neurologic

- Hydrocephalus/shunt
- Tethered Cord
- Chiari II Malformation
- Hydromyelia
- Paralysis due to Spinal Cord Injury
- Seizure Disorders

Medical/Orthopedic

- Allergies
- Cancer
- Poor Endurance
- Recent Surgery
- Diabetes
- Peripheral Vascular Disease
- Varicose Veins
- Hemophilia
- Hypertension
- Serious Heart Condition
- Stroke (Cerebrovascular Accident)

Secondary Concerns

- Behavior Problems
- Age under two years
- Age two – four years
- Acute exacerbation of chronic disorder
- Indwelling catheter

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

Physician Name (please print): \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

Date: \_\_\_\_\_

RIDER SIGNATURE (if over 18): \_\_\_\_\_

Date: \_\_\_\_\_

Please return this form to: Stajduhar Physical Therapy  
2901-B Martin Drive  
Bedford, TX 76021  
(817) 503-8130 fax

## **Stajduhar Stables Release of Liability**

Name of Rider \_\_\_\_\_

Stajduhar Physical Therapy, or its officers, members, employees and agents will not be responsible for any damages to person, animal or property at Stajduhar Stables its grounds, nor will they be responsible for any property lost or destroyed. The undersigned rider/parent/ guardian or volunteer hereby releases Stajduhar Physical Therapy, its officers, members, employees and agents from any and all liability, claims, and damages whatsoever (including costs, expenses, and attorney's fees) that might result from damages, injuries, or losses to their person or property during, or in connection with, or arising out of any show, clinic, event or function, whether or not such damages, injuries, or losses result or indirectly from the negligent act or omission of such released parties.

***Warning: Under Texas Law (Chapter 87, Civil Practice and Remedies Code), An 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.***

In exchange for the use of property owned by Stajduhar Physical Therapy and other valuable consideration, I agree that my use of the premises and any animals, facilities, or equipment owned by Stajduhar Physical Therapy is at my own risk. I further agree to indemnify and hold harmless Stajduhar Physical Therapy, their respective officers, members, employees, and agents from any and all suits, actions, or claims of any type arising from my use of the premises or participation in the equine activity of such use by my guest, whether or not such claims result directly or indirectly from the negligent act or omissions of the indemnifies parties or otherwise.

I acknowledge that riding and involvement with horses is a high risk activity. I have read this agreement and fully understand its content.

Please sign here: \_\_\_\_\_  
(Adult rider OR Parent/guardian/caregiver of minor child OR Volunteer)

## **Stajduhar Stables Photo Release**

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to Stajduhar Stables permission to take or have taken still and moving photographs and films, including television pictures and consents and authorizes Stajduhar Stables, its advertising agencies, news media, and any other persons interested in Stajduhar Stables and its work, to use and reproduce the photographs, films or pictures and to circulate and publicize the same by all means, including, without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional materials, books, and clinical materials.

With respect to the foregoing matters, no inducements or promises have been made to secure this signature to this release other than the intention of Stajduhar Stables to use or cause to be used such photographs, films, and pictures for the primary purpose of promoting Stajduhar Stables to its work.

I GIVE CONSENT: \_\_\_\_\_  
(Adult rider or parent/guardian/caregiver of minor rider)

DATE: \_\_\_\_\_

I DO NOT GIVE CONSENT: \_\_\_\_\_  
(Adult Rider or parent/guardian/caregiver of minor Rider)

DATE: \_\_\_\_\_

# Stajduhar Stables Consent for Emergency Medical Treatment

RIDER NAME \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(Street) (City) (State) (Zip)

TELEPHONE \_\_\_\_\_ DOB \_\_\_\_\_  
(Home) (Work)

RIDER'S DISABILITY \_\_\_\_\_ DATE OF ONSET \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHYSICIAN'S TELEPHONE \_\_\_\_\_

Person who is authorized to give temporary assistance or care in absence of parent or guardian:

Name \_\_\_\_\_

Telephone \_\_\_\_\_ Relationship \_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Describe any medical condition requiring special precautions or treatment and any medications and dosage:

A None \_\_\_\_\_

B Please describe \_\_\_\_\_

In case of medical emergency, the undersigned authorizes Stajduhar Stables to provide such medical assistance as they determine to be necessary. If the rider named above is younger than 18 years, the undersigned authorizes Stajduhar Stables, acting through the adult on its staff who has actual care, control and possession of the child to consent to medical, dental, and surgical treatment of the child when the undersigned cannot be contacted. The undersigned represents to Stajduhar Physical Therapy that he or she is the child's parent and either (i) is not divorced from the other parent, or (ii) is divorced from the other parent, but has been authorized by a written court order to give consent to medical and dental care and surgical treatment of the child. The undersigned will indemnify and hold Stajduhar Physical Therapy, its officers, members, employees and agents harmless if he or she is not empowered by law to give this consent. The undersigned authorizes any licensed physician and /or medical facility to provide any medical/surgical care and/or hospitalization for the child, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned. No person can be accepted for riding instruction or hippotherapy until this form has been completed by the parent/parents or guardian. If the person is of legal age (18), he or she may complete the form, if he or she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including Stajduhar Physical Therapy.

Yes, I would like \_\_\_\_\_ to have riding instruction or hippotherapy at Stajduhar Stables. If my child is a rider, I have discussed this with the rider's doctor. I understand that NO LIABILITY can be accepted by any organization concerned with this instruction, including Stajduhar Physical Therapy, in the event of any accident which may occur.

\_\_\_\_\_  
SIGNATURE OF PARENT/PARENTS OR GUARDIAN DATE

\_\_\_\_\_  
SIGNATURE OF RIDER IF OVER AGE 18 DATE

\_\_\_\_\_  
INSURANCE CARRIER POLICY NUMBER

**Stajduhar Stables**  
**Non-Consent For Emergency Medical Treatment**

(Fill out only the Consent or Non-Consent form, not both.)

Rider Name \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

(Street)                      (City)                      (State)                      (Zip)

TELEPHONE \_\_\_\_\_ DOB \_\_\_\_\_

(Home)                      (Work)

**I do not give my consent** for emergency medical treatment/aid in the event of illness or injury during the process of receiving services or any participation on my part at Stajduhar Stables. In the event emergency treatment is required, I authorize Stajduhar Stables or its representatives to take the following action in my behalf.

Please notify the following the event of emergency:

Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Name \_\_\_\_\_

Phone Number \_\_\_\_\_

No person can be accepted for participation at Stajduhar Stables until this form has been completed. If the person is of legal age (18), he/she may complete the form. If the person is not of legal age, the form must be completed by the parent/parents or guardian. Riding instruction and program activities will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including Stajduhar Physical Therapy.

Yes, I would like \_\_\_\_\_ to have riding instruction at Stajduhar Stables. If my child is a rider, I have discussed this with the rider's doctor. I am the parent/guardian of \_\_\_\_\_.

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SIGNATURE OF RIDER IF OVER 18 \_\_\_\_\_ DATE \_\_\_\_\_

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SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

## **Notice of Privacy Practices** **Stajduhar Physical Therapy**

Our legal duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

### Use and Disclosures of Health Information:

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide you. Health care Operations: We may use or disclose your health information in connection with our healthcare operations. Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up health information or medical supplies or other similar forms of health information. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. Required By Law: We may use or disclose your health information when we are required to do so by law. Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials your health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmates or patients under certain circumstance. Appointment Reminders: We may use or disclose a portion of your health information to provide you with appointment reminders and school excuses (such as voicemail messages, postcards, or letters).

### Patient Rights:

Access: You have the right to look at or obtain copies of your health information, with limited exceptions. Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

### *Acknowledgement of Receipt of Notice of Privacy Practices*

I, \_\_\_\_\_ have received a copy of the Notice of Privacy Practices for Stajduhar Physical Therapy.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_