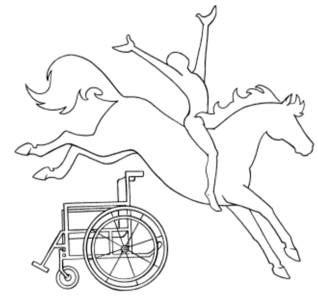
# Ride On

## Therapy Services



**Serving the San Fernando and Conejo Valleys**

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

401 Ronel Court, Thousand Oaks, CA 91320 10860 Topanga Canyon Blvd., Chatsworth CA 91311
(805) 375-9078 Fax (805) 375-8640 www.RideOn.org
A 501 (c) (3) non-profit corporation. Tax ID: 95-4465783

**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*
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# Therapy Services- RO

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**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:*

| | Y | N | Comments |
|---|---|---|---|
| Vision | | | |
| Hearing | | | |
| Sensation | | | |
| Communication | | | |
| Heart | | | |
| Breathing | | | |
| Digestion | | | |
| Elimination | | | |
| Circulation | | | |
| Emotional | | | |
| Behavioral | | | |
| Pain | | | |
| Bone/Joint | | | |
| Muscular | | | |
| Thinking/Cognition | | | |
| Allergies | | | |
| Other | | | |

**--- OVER ---**

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*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 |
|---|---|
| WEDNESDAY afternoon | Y / N |
| THURSDAY morning | Y / N |
| THURSDAY afternoon | Y / N |
| FRIDAY morning | Y / N |

***Only PT Available**

| NEWBURY PARK: | YES / NO |
|---|---|
| TUESDAY afternoon | Y / N |
| WEDNESDAY afternoon | Y / N |
| THURSDAY afternoon | Y / N |

***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

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**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 ---**

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# 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)

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***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: ___________________________________________________

Expiration: __________ Security Code: _______ Billing Zip code: _______

___ 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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## PRESCRIPTION

**Patient:** ______________________________ **Date:** ____________________

**Address:** ______________________________________________________

**Phone:** ______________________ **Date of Birth:** ______________________

**Diagnosis:** ______________________ **Date of Onset:** ______________________

| PHYSICAL THERAPY | OCCUPATIONAL THERAPY |
| --- | --- |
| ☐ physical therapy evaluation | ☐ occupational therapy evaluation |
| ☐ physical therapy treatment | ☐ occupational therapy treatment |
| ☐ other ____________ | ☐ other ____________ |

### SPEECH/LANGUAGE THERAPY

☐ speech/language therapy evaluation
☐ speech/language therapy treatment
☐ other ____________

**Frequency:** ______________________ **Duration:** ___ ☐ 1 year __________
___ ☐ other __________

**Precautions/Comments:** ______________________________________________

______________________________________________________________

______________________________________________________________

**PLEASE PRINT**

Name/Title: ______________________________ MD DO NP PA other ______________

Signature: ______________________________ Date: ______________

Address ______________________________________________________

City: ______________ Zip: ________ Phone: (_____)______________________

Fax: (______)______________________License/ UPIN Number:______________________

Email: ______________________________________________________

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# Ride On

## Enrollment Form

Information on annual family income is required to determine client elegibility 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

| First Name | | Last Name | |
|---|---|---|---|
| Address | Apt. # | City | Zip Code |
| Phone # ( ) | Birthdate ______/_______/_____Age: ______ | Gender ☐ Male ☐ Female | |

Please Check All That Apply

| Disability | Education Level | Customer Family Type |
|---|---|---|
| ☐ Disabled Adult (16 and Over) | ☐ 0 - 8th Grade _______ | ☐ Single Adult |
| ☐ Disabled Child (15 and Under) | ☐ 9 - 12th Grade ______ | ☐ Two Adults No Children |
| ☐ None | ☐ 2 or 4 Year College Degree | ☐ Single Parent |
| | ☐ High School Grad / GED | ☐ Two Parent Family |

| Race (please check one of the following categories) | | Ethnicity (check One) |
|---|---|---|
| ☐ American Indian Or Alsakan | ☐ Asian AND White | ☐ Hispanic/Latino |
| ☐ Asian | ☐ Black or African American AND White | ☐ Not Hispanic /Latino |
| ☐ Black or African American | ☐ American Indian AND Black/AfricanAmerican | |
| ☐ Native Hawaiian or other Pacific Islander | ☐ Balance/Other | |
| ☐ White (not Hispanic or Latino) | | |

***2019 CDBG Income Guidelines (Circle one)***

| Family Size | B: Income | C: Income | D: Income | E: Income |
|---|---|---|---|---|
| 1 Person | $0 - $21,950 | $21,951 -$36,550 | $36,551 - $58,450 | $58,451 + |
| 2 Persons | $0 - $25,050 | $25,051 - $41,800 | $41,801 - $66,800 | $66,801 + |
| 3 Persons | $0 - $28,200 | $28,201 - $47,00 | $47,001 - $75,150 | $75,151 + |
| 4 Persons | $0 - $31,300 | $31,301 - $52,200 | $52,201 - $83,500 | $83,501 + |
| 5 Pesons | $0 - $33,850 | $33,851- $ 56,400 | $56,401 - $90,200 | $90,201+ |
| 6 Persons | $0 - $36,350 | $36,351 - $60,600 | $60,601 - $96,900 | $96,901 + |
| 7 Persons | $0 - $38,850 | $38,851 - $64,750 | $64,751 - $103,550 | $103,551 + |
| 8 Persons | $0 - $41,350 | $41,351 - $68,950 | $68,951 - $110,250 | $110,251 + |

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: __________