



# Equine Assisted Therapy

Health, Happiness and Healing through Horses since 1988

Dear Clients and Families:

Thank you for your interest in the Equine Assisted services at Horses of Hope Oregon. Our programs are dedicated to 'health, happiness and healing through horses' and improving clients' lives by promoting wellness, enhancing capabilities, and fostering independence.

It is a pleasure to work with you in our Equine Assisted services. These programs are only possible due to the generosity of the community, donors, and our volunteers. We're confident you will enjoy getting to know the volunteers and instructors working with you.

Horses of Hope Oregon (HOH) has been serving children and adults with challenges through equine assisted therapeutic activities since 1988, and you will find our staff to be experienced, skilled, and caring. HOH's instructors utilize our horses to facilitate interactive games and skill-building movements tailored to each person's needs. Interactions with horses help people gain independence and self-esteem. We strive to find what each person is capable of and tailor each lesson to the participant's goals. Therapeutic riding is linked to cognitive and emotional benefits and physical improvements in balance, motor skills, sensory integration, and muscle strength. Our therapy horses allow people to find a sense of connection – these are emotional animals with unedited feelings. There is a straightforward, easy-to-read quality to horses that is comforting. Our horses are not just incredible athletes, but are also non-judgmental, dependable, caring and kind. They can bring emotional stability to our lives and renew confidence in our own abilities.

**When you arrive:** The driveway is on the east side of the stable. Please ***drive slowly*** and watch out for farm equipment, animals, and pedestrians. Proceed to the front of the stable (which faces Cloverdale Drive) where you will find parking.

**Once inside:** You will find a signup sheet on the table in the foyer. Please sign in as soon as you arrive. ***Everyone*** in your party must sign an inherent risk waiver, which is also on the table.

**Stay in the designated areas:** Remember this is a working stable and although we maintain a warm and friendly environment, it is not appropriate to pet or feed the horses without consent. Our work here is fun and easily generates excitement for siblings. Please remember to keep siblings safe by staying with them at all times, in the designated areas. Please walk quietly or sit quietly at the facility. No running please. There is no childcare, although we do have a playroom with lots of toys and books.

We hope that you have begun to feel the spirit of health, happiness and healing that we strive for here at HOH. We look forward to seeing you soon.

Sincerely,

***The Staff at Horses of Hope***



## Riding Schedule and Fees

This form must be newly signed for the 2021 Annual Program

### Evaluation

HOH's professionals will discuss our Equine Assisted Therapeutic programs with you. We first schedule an intake appointment. The purpose of this on-site appointment is for the client and their caregiver to visit the Stable, meet our staff and horses, and discuss objectives, needs, and goals for Equine Assisted Therapeutic sessions.

### Program Fees

*Payment for services is due prior to services provided.*

All participants will receive an invoice around the 20<sup>th</sup> to 25<sup>th</sup> of each month and **payment is due and payable by the 5<sup>th</sup> of the following month**. Your invoice will reflect your monthly program fee for the following month. **Your monthly program fee of \$146 (weekday) or \$140 (Saturday) has already taken into account any dates on the calendar that Horses of Hope has planned to close for holidays, special events and trainings.** This allows participants to plan their budgets by providing a consistent amount due every month.

Horses of Hope provides all sessions at 75%-80% of the actual cost (between \$700-\$800 per month). We understand that even so, financial constraints are a barrier for participation for some of our clients. We have partnered with some generous donors to create a scholarship fund to help those clients. Funds are dispersed in January of each year, but may be available at other points in the year. Scholarship applications are available on request. Scholarships cover between 35%-65% of the program fee. A scholarship application can be requested from the office in person or by emailing office@hohoregon.org

Our billing policy has been created to reflect our belief that participants are best served through consistent and long-term involvement with therapeutic sessions. While we will do our best to accommodate short-term participants, we want to honor the commitment of our long-term participants, and will accommodate long-term, weekly participants first on the schedule.

Because Horses of Hope offers therapeutic sessions to all our clients at a rate significantly lower than our actual cost, we respectfully request that you pay your bill on time every month so we can continue to provide these services to everyone. *We will not be able to offer sessions to clients with outstanding unpaid fees.*

Finally, if Horses of Hope adds a canceled date to the calendar, or has to cancel for weather or other reasons, participants whose sessions were cancelled by HOH will receive a credit to their account for the following month, calculated by prorating your monthly program fee.

**\*\* I have read and understand the above policy:**

\_\_\_\_\_   
 Print Participant Name

\_\_\_\_\_   
 Signature of Participant or Guardian/Responsible Party

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

### Payment Options

We can accept client payments online, through our GoPayment invoicing program, by credit card, check or cash.

Friends and family can help cover your program fees. We can bill them directly or you may suggest that they contact us for payment information. Please call Horses of Hope's office at (503) 743-3890 with any questions.



## CLIENT INFORMATION SHEET

The following information will be used by HOH, to help create the most appropriate riding situation possible for prospective clients. Please answer these questions carefully and honestly to the best of your ability. If you do not understand a question, please don't hesitate to call and ask for assistance at 503-743-3890. If you find a question that does not apply to your situation, write N/A for non-applicable.

<b>Client name:</b>	_____		
<b>Address:</b>	_____		
<b>City:</b>	_____	<b>State:</b>	_____
		<b>Zip:</b>	_____
<b>Phone:</b>	_____	<b>Cell:</b>	_____
<b>E-mail:</b>	_____		
<b>Height:</b>	_____	<b>Weight:</b>	_____
<b>Date of Birth:</b>	_____	<b>Sex:</b>	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other/prefer not to disclose
<b>Therapist (PT / OT / SLP):</b>	_____		
<b>Therapist phone:</b>	_____		
<b>Ethnicity:</b>	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Latino <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Alaska Native/Native American <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> I Prefer Not To Disclose		

<b>Responsible Financial Party Name:</b>	_____		
<b>Relationship to Client:</b>	_____		
<b>Address:</b>	_____		
<b>City:</b>	_____	<b>State:</b>	_____
		<b>Zip:</b>	_____
<b>Phone:</b>	_____	<b>Cell:</b>	_____
<b>E-mail:</b>	_____		

<b>I have read and understand the Riding Schedule &amp; Payment Policy</b>			
Signature: _____			
<b>Print full name:</b>	_____	<b>Date:</b>	_____

Photo taken within the last 12  
months

## PHOTO

Photo is not required, but  
requested, as it helps us  
identify the client

PLEASE COMPLETE, SIGN AND RETURN:

1. **Client Information Form**
2. **Client Questionnaire**
3. **Client Orientation Form**
4. **Participant Agreement**
5. **Request & Release**
6. **Photo Agreement**
7. **Confidentiality Agreement**
8. **Emergency Preparedness Form**
9. **Riding Schedule and Fees**

PLEASE RETURN COMPLETED APPLICATION TO:

**Horses of Hope Oregon**  
**2895 Cloverdale Drive SE**  
**Turner, OR 97392**

For office use only:

Date received \_\_\_\_/\_\_\_\_/\_\_\_\_



## CLIENT QUESTIONNAIRE

Please fill out this page so that we know if you have any conditions that could affect your balance, health, or safety while riding.

<b>DIAGNOSIS OR DISABILITY:</b> (Please note multiple diagnoses if applicable)			
<b>IS CLIENT AMBULATORY:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>ADAPTIVE APPLIANCES USED:</b> (wheelchair, crutches, etc.)	_____		
<b>SEIZURES:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>Explain:</b>	_____		
<b>CONTRACTIONS:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>Explain:</b>	_____		
<b>SPASTICITY:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>Explain:</b>	_____		
<b>FUSIONS:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>Explain:</b>	_____		
<b>FRAGILITY:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>Explain:</b>	_____		
<b>FATIGUE:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>Explain:</b>	_____		
<b>PRESSURE SORES?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>CAN CLIENT SIT WITHOUT SUPPORT?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>CAN CLIENT TRANSFER WITHOUT HELP?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>DOES CLIENT TIRE EASILY?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>HAS CLIENT RIDDEN BEFORE?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N		

<b>VISION:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
<b>HEARING:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
<b>SPEECH:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
<b>BALANCE:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
<b>NECK STRENGTH:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
<b>ARM STRENGTH:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None

<b>HAND DEXTERITY:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
<b>EYE HAND COORDINATION:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
<b>TRUNK STRENGTH:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
<b>LEG STRENGTH:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
<b>HIP FLEXION:</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None

<b>RATE PAIN SENSITIVITY:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Above Normal	<input type="checkbox"/> Below Normal
<b>RATE HEAT SENSITIVITY:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Above Normal	<input type="checkbox"/> Below Normal
<b>RATE COLD SENSITIVITY:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Above Normal	<input type="checkbox"/> Below Normal
<b>RATE SENSITIVITY TO TOUCH OR TEXTURES:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Above Normal	<input type="checkbox"/> Below Normal

<b>Additional Information:</b> (use additional page(s) if necessary)



## CLIENT ORIENTATION

**Carefully read, sign, and return. If you do not understand the information provided, please ask our staff to explain.**

- All clients, parents, and guardians are required to read and sign a liability waiver prior to participation.
- Please keep children under your control at all times.
- **Maximum weight for riding is 225 pounds.** We seek to accommodate everyone, so clients exceeding this weight limit can meet with staff to discuss full participation.
- Personal pets are not permitted.
- **Long pants** are recommended.
- **Closed-toed shoes with a heel are required** (no sneakers or sandals please).
- Recreational use of drugs or alcohol is **not** allowed prior to or during equestrian activities.
- Horses of Hope Oregon staff and volunteers will not discriminate on the basis of a client’s race, religion, gender, age, national origin, ancestry, economic status, or mental or physical disability.
- If minors participate in HOH programs unaccompanied by a parent or legal guardian, HOH staff shall have full authority with regards to the minor’s behavior, participation, and emergency medical treatment.
- Each client must wear an A.S.T.M. approved equestrian helmet before mounting. If you don’t have a helmet, we will provide you with one. Helmet waivers are available if you have a medical reason for not wearing one.
- If you have any questions regarding these procedures, please discuss them with staff prior to the beginning of your ride. Your participation in this activity signifies full acceptance of all rules and conditions.
- Your cooperation will help us to provide an enjoyable horseback adventure.
- Because equine-assisted sessions work best when participation is consistent, if your attendance falls below 75% for more than a month, we will contact you to determine if this program is the right fit for you at this time. Our session schedule often has a waiting list, and we will prioritize clients who can make their scheduled sessions consistently.

<b>Signature of client, parent, or guardian:</b>			
<b>Print full name:</b>		<b>Date:</b>	

## **PARTICIPANT AGREEMENT, RELEASE AND ASSUMPTION OF RISK**

In consideration of the services of Horses of Hope Oregon, their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as 'HOH'), I hereby agree to release, indemnify, and discharge HOH, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I acknowledge that horse activities entail known and unanticipated risks that could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

**The risks include, among other things:** contact with wild animals, hiking and exposure to the elements. A horse, regardless of its training and usual past behavior, may act unpredictably at times based upon instinct or fright which may cause you to be thrown from your horse or injured by the horse. Horses may do such things as bite, kick, buck, lie down, or stumble. Saddles may slip and other tack or saddle problems may develop as a result of normal use and wear. Your horse may collide with obstacles or encounter variations in terrain such as creeks, water, bridges, traveled roads, wild animals, birds, stump, forest growth, debris, rocks and cliffs and other obstacles whether obvious or not and whether man made or natural. Each of those obstacles or variations in terrain could cause you to lose control of your horse and you could fall. Riding a horse requires the participant to balance on the saddle. Participants may lose their balance that can result in falling from the horse.

Furthermore, HOH employees have difficult jobs to perform. They seek safety, but they are not infallible. They might be unaware of a participant's fitness or abilities. They might misjudge the weather or other environmental conditions. They may give incomplete warnings or instructions, and the equipment being used might malfunction.

2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless HOH from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of HOH's equipment or facilities, **including any such claims which allege negligent acts or omissions of HOH.**

4. Should HOH, the property owner, or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

5. I certify that I have adequate insurance to cover any injury or damage I may suffer while participating, or else I agree to bear the costs of such injury or damage myself. I further certify that I am willing to assume the risk of any medical or physical condition I may have.

6. In the event that the lessee files a cause of action against HOH, the lessee agrees to do so solely in the state of Oregon, and further agrees that the substantive law of that state shall apply in that action without regard to the conflict of law rules of that state. The lessee agrees that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.





**By signing this document, I acknowledge that if I am hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against HOH, its staff, Board of Directors, Therapists, volunteers, and Property Owner on the basis of any claim from which I have released them herein.**

**I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.**

Signature of Participant \_\_\_\_\_

Print Name \_\_\_\_\_

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

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

Phone: Day: \_\_\_\_\_ Eve: \_\_\_\_\_

Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PARENT'S OR GUARDIAN'S ADDITIONAL INDEMNIFICATION  
(Must be completed for participants under the age of 18)**

In consideration of \_\_\_\_\_  
(Print minor's name)

("Minor") being permitted by HOH to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold harmless HOH from any and all Claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Parent or Guardian: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_



## **PHOTO AGREEMENT**

I, the undersigned, grant to Horses of Hope Oregon, hereafter referred to as 'HOH', and/or their assignees permission in perpetuity throughout the world to use my likeness, performance, recording, and/or voice as photographed and/or recorded by them for still or motion picture uses, internet - including website and Facebook, or any other use connected with the promotion, exhibition, marketing or benefit of 'HOH's' programs.

I hereby release HOH, its assignees, licensees, and successors including, but not being limited to, all networks, stations, sponsors, publishers, distributors and exhibitors from any and all claims, liabilities, demands, or causes of action which I have or may hereafter have, by reason of photographing, recording, broadcast, exhibition, or any other uses of such films or recordings that may be from time to time made, or by reason of any occurrence or circumstance that may have taken place in or in conjunction with the photographing or recording of any scenes.

The undersigned further agrees that HOH shall own all rights, title and interest including any copyright in and to anything produced pursuant to the right granted HOH and that this waiver and release is binding on the heirs of the undersigned.

### **PLEASE PRINT**

Participant's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

### **I AFFIRM THAT I AM MORE THAN 18 YEARS OF AGE**

Signature \_\_\_\_\_ Date \_\_\_\_\_

If participant is less than 18 years of age, parent or guardian must complete the following guardian consent.

I am the parent or guardian of the above-mentioned participant. I hereby approve the foregoing and consent to the terms mentioned above. I affirm that I have the legal right to issue such consent.

### **PLEASE PRINT**

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Phone \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed by \_\_\_\_\_ Date \_\_\_\_\_



## **Confidentiality Agreement**

**I understand that each client's pertinent medical information may be discussed between staff and volunteers for the participant's safety and benefit. We keep a record of each person's medical diagnosis / disability / challenge. This allows staff to be informed of any special safety issues. Individualized emergency plans are developed accordingly. Riding sessions are also individualized based on the client's medical needs.**

**Any information regarding the participants (clients) at Horses of Hope Oregon will be held in strict confidentiality. For the purposes of grant funding and public relations, the client's success story may be shared at public meetings or conferences, with identity protected. Photos will only be shared with the client's permission (written photo release).**

Signature of Participant \_\_\_\_\_

Print Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### **PARENT'S OR GUARDIAN'S ADDITIONAL INDEMNIFICATION (Must be completed for participants under the age of 18)**

In consideration of \_\_\_\_\_ (print minor's name) ("Minor") being permitted by HOH to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold harmless HOH from any and all Claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Parent or Guardian: \_\_\_\_\_ Print Name:  
\_\_\_\_\_

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



## EMERGENCY PREPAREDNESS CARD

<b>NAME:</b> _____	<b>DATE OF BIRTH:</b> ____/____/____
<b>CONTACTS &amp; PHONE #'S (RELATIONSHIP):</b>  1. _____ — 2. _____ — 3. _____ —	<b>MEDICAL INFORMATION &amp; HISTORY:</b> _____ _____ _____ _____
<b>PHYSICIAN:</b> _____ — _____	<b>ALLERGIES / ASTHMA:</b> _____ _____
<b>HEALTH CARE PLAN (S):</b> _____ _____	<b>ALLERGIES TO MEDS:</b> _____ _____

**OTHER:** \_\_\_\_\_

**CURRENT MEDICATION:**

NAME OF MEDICATION	AMOUNT	HOW OFTEN?

**Print Name of person completing form:** \_\_\_\_\_ **Date** \_\_\_\_\_