# BITS of Freedom

## Therapeutic Riding Center

**8180 Even Rd**
**Beulah, CO**
**Phone:719-369-9756**

***Client Registration and Release Form***

**All Client Registration paperwork must be updated annually.**

**For office use only:**
QB:

DQ:

Client Name _____ Date of Birth _____ Age _____

Street _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

School or program presently attending _____

Parent or Guardian _____

Address (if different from above) _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____ Employer _____

Thank you for your interest and participation in Bits of Freedom programs. To stay in touch, share news and happenings at BITS we use text messaging, voice mail, email and direct mail. **TO OPT OUT please indicate here any method(s) of communication you do not want us to use:** _____

Contact for Scheduling Lessons (include Caregiver info here if applicable) _____

Phone _____ E-mail _____

**In case of an emergency please contact:**

Name _____ Phone _____

Name _____ Phone _____

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**Liability Release: (Mandatory to participate)**
The Client and/or the Client's Parents/Guardians acknowledge that they have been given an opportunity to read and consider the attached Participation Waiver and Release Agreement (page 3) and that by signing below they are agreeing to the terms of the Participation Waiver and Release. The Client and/or the Client's Parents/Guardians understand that this document contains an express assumption of risk, a promise not to sue, and a waiver, release and indemnity for all claims.

Signature _____ Date _____
(Client or Parent/Guardian if participant is under 18)

Printed Name _____ Relationship _____

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**Photo/Video Release (optional):** I hereby give my consent and authorize Bits of Freedom to use and reproduce any and al photographs or videos taken of the above-named client for promotional printed/video materials, educational activities or for any other use which would benefit Bits of Freedom Therapeutic Riding Center

Consent Signature _____ Date _____
(Client or Parent/Guardian, if under 18)

Non-Consent Signature _____ Date _____
(Client or Parent/Guardian, if under 18)

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**Physician/Medical Professional Release:** In my opinion, this individual can participate in supervised riding activities. As it relates to these activities, I concur with the referral of this individual to a physical or occupational therapist or other health care professional, if indicated, for evaluation of their abilities/limitations, in order to implement an appropriate and effective therapeutic riding program.

Physician/Medical Professional Name (please print) _____ Phone _____

Practice Address _____

Physician/Medical Professional Signature _____ Date _____

**Please complete all pages: Incomplete registrations cannot be accepted and will hinder the registration process.**

**BITS of Freedom therapeutic Riding Program**
**MEDICAL HISTORY/AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

Name_____ Parent/Guardian_____

Diagnosis_____ Date of Onset_____ Date of Birth_____

Height _____ Weight_____ Medications_____

Seizures: Yes No Type_____ Controlled: Yes No Date of last seizure _____

Tetanus Shot: Yes No Date of last shot/booster _____

Bits of Freedom is a therapeutic riding program designed to benefit participants physically, socially and emotionally. Safety equipment, specially trained horses and volunteers are used. In order to assure optimal protection and the greatest personal benefit from the program, each client is required to furnish the following medical information before being accepted as a client. ****Note:** Because of the nature of the activity of horseback riding, individuals with the diagnosis of **Down Syndrome** must have documentation that certifies that the individual has no signs of AAI or focal neurologic disorder. Please indicate if impairments exist in any of the following areas by checking yes or no. If yes, please comment, using attachments if necessary.

| Areas | Yes | No | Comments |
|---|---|---|---|
| Hearing | | | |
| Vision | | | |
| Speech | | | |
| Heart/Circulatory | | | |
| Breathing | | | |
| Neurological | | | |
| Muscular/Orthopedic | | | |
| Learning Disability | | | |
| Allergies | | | |
| Cognitive Impairment | | | |
| Other | | | |

Primary Means of Mobility: Walks (with or without assist): ☐ Yes ☐ No; Assistive Device:_____
Wheelchair User: ☐ Yes ☐ No; Braces: ☐ Yes ☐ No

Please indicate any other special precautions:_____

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

In the event that emergency medical aid and/or treatment is required due to illness or injury, I authorize Bits of Freedom Therapeutic Riding Center to:

1. Secure medical treatment and transportation if needed on my behalf.
2. Release client records upon request to the authorized individual(s) or agency involved in the emergency care.

Physician's/Medical Professional's Name Name:_____ Phone _____

Preferred Medical Facility if Emergency Care is needed:_____

Health Insurance Company:_____ Policy #_____

**Consent Plan:**
This authorization includes x-ray, surgery, hospitalization, medication and any other treatment procedures deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Consent Signature: _____ Date:_____
(Client, Parent or Guardian if under 18)

**Non-Consent Plan:**
I do not consent to emergency medical treatment/aid or hospitalization in the case of illness or injury. In the event that emergency care is required, I request the following procedures be followed: _____

_____

Non-Consent Signature: _____ Date: _____
(Client, Parent or Guardian if under 18)

**BITS of Freedom/ Michelle Even**
**PARTICIPATION WAIVER AND RELEASE AGREEMENT**

**Name:**_____

This Participation Waiver and Release Agreement is made by and between the undersigned client, volunteer or participant in an equine activity or equine event (the "Participant"), the Participant's parents, guardians, or conservators if the Participant is a minor or ward ("Participant's Parents or Guardians"), and BITS of Freedom Therapeutic Riding Program, Michelle Even, (the "Equine Sponsor" and/or "Equine Professional"). This Agreement is a requirement and condition of partici- pation in any equine activity or equine event conducted, provided, operated, organized or sponsored by the Equine Activity Sponsor or Equine Professional on whose property, facilities, animals, equipment or personnel are used in such connection.

In consideration of the opportunity to participate in equine activities or equine events, the Participant and, if a minor or ward, Participant's Parents or Guardians agree as follows.

1. Inherent Risks. The Participant and Participant's Parents or Guardians acknowledge and understand that horses and activities related to horses are inherently dangerous and that those dangers and conditions integral to equine activities or equine events include, but are not limited to, the propensity of horses to behave in ways that may result in damage to property or injury, harm, or death to persons on or around them (including behaviors such as bucking, biting, rearing, stepping on, falling, stumbling and shying); the unpredictability of a horse's reaction to sounds, movements, unfamiliar objects, persons, or other animals; certain hazards such as surface and subsurface conditions; collisions with other horses, Clients, or objects; the potential for the Participant to act in a negligent manner or otherwise fail to maintain control over the animal; and unpredictable or erratic actions by others on or near animals. Despite these inherent risks, the Participant has chosen, and Participant's Parents or Guardians have chosen to permit the Participant to work with and around horses and participate in equine activities and equine events. The Participant and Participant's Parents or Guardians have considered the Participant's particular physical, mental, and emotional condition or challenges in making this participation decision.

2. Duties and Obligations; Statutory Assumption of Risk and Limitation of Liability. The Participant and Participant's Parents or Guardians are advised that under Colorado law, with certain limited exceptions, an equine activity sponsor, equine professional or any other person engaged in an equine activity is not liable for any property damage or damages arising from the personal injury or death of a participant or spectator resulting from the inherent risks of equine activities. The Participant and Participant's Parents or Guardians are further advised that Colorado law provides that each participant and spectator in an equine activity expressly assumes the risks and legal responsibility for any property damage or damages arising from personal injury or death that results from the inherent risks of equine activities. Each Participant has the sole responsibility for knowing the range of that person's ability to manage, care for and control a particular horse or perform a particular equine activity. It is the duty of each Participant to act within the limits of the Participant's own ability, to maintain reasonable control of the horse at all times while participating in any equine activity or event, to heed all warnings and instructions, and to refrain from acting in a manner that may cause or contribute to the injury of any person or damage to property. The Participant and Participant's Parents or Guardians understand these duties and obligations and have considered the Participant's particular physical, mental, and emotional condition or challenges in undertaking this express assumption of risk.

3. Release and Waiver. The Participant and Participant's Parents or Guardians understand the risks and dangers inherent in equine activities and do hereby waive and agree not to make any claim or seek any recovery from the Equine Activity Sponsor and Equine Professional and their respective directors, officers, trustees, shareholders, employees, contractors, agents, and assigns for any property damage or damages for personal injury or death resulting from the inherent risks of equine activities. The Participant and Participant's Parents or Guardians hereby further release and discharge the Equine Activity Sponsor and Equine Professional and their respective directors, officers, trustees, shareholders, employees, contractors, agents, and assigns from any and all actions, causes of actions, liabilities, claims, demands, damages, costs and expenses of any kind including, but not limited to, any claim of damages for bodily injury, illness, disease, death or loss of personal property now existing or which may in the future occur or result, directly or indirectly, from participation or involvement in any equine activity, program, or event. The Participant and Participant's Parents or Guardians understand and agree that this Release and Waiver is intended to be as broad as the law allows and specifically covers all claims or demands that may be based in whole or in part on the fault or negligence of the Equine Activity Sponsor and Equine Professional and their respective directors, officers, trustees, shareholders, employees, contractors, agents, and assigns.

**WARNING**

**UNDER COLORADO LAW, AN EQUINE ACTIVITY SPONSOR, EQUINE PROFESSIONAL, OR OTHER PERSON ENGAGED IN EQUINE ACTIVITIES HAS LIMITED LIABILITY FOR INJURY OR DEATH RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES (7 M.R.S.A. §§ 4101; 4103-A).**

**Client Name:**_____

## ~ Scheduling~

Please indicate below the days/times that are most convenient for you/your child and any days/times that do not work for you (e.g. therapy days, regular appointments, etc.). There are many factors involved in scheduling and we do our best to consider your preferred times when scheduling lessons.

_____

_____

## ~ Cancellation Policy ~

BITS of Freedom charges tuition for each term/semester. If less than halfway through a term/semester a participant is no longer able to attend for a valid medical reason or family emergency, please contact the BITS Office Manager or Executive Director. We will discuss options for a credit towards a future session or, if another participant can be found to fill your lesson time slot, a partial refund of your tuition payment. Client cancellations are not refundable and due to scheduling constraints are not able to be made up. For cancella- tions that are due to weather or initiated by BITS , credits will be issued. If a client is not continuing past the end of the term/semester, a refund may be requested.

## ~ Payment Policy ~

BITS of Freedom requests tuition payment in full in advance for any term/semester. In select cases where payment in full is a financial hardship, a payment plan may be arranged, but a deposit is required prior to the start of a term/semester and payments must be kept current.

Scholarship recipients are responsible for paying their portion of the tuition bill in advance of the session or through an agreed upon payment plan. ***All*** clients must have their account paid in full from the previous term/ semester before continuing into another term/semester. We accept cash, checks and all major credit cards.

BITS of Freedom ***does not*** bill any insurance companies. However, BITS has a generous Financial Aid program and various agencies and foundations do provide funding for
Equine Assisted Activities and Therapies. If you have received such an award, please fill out the information below.

❒ **I /we have enclosed the necessary award letter and contact information for billing an agency**

**Agency Name:** _____**Billing Contact Person:**_____

**Mailing Address:**_____ **City/State/Zip:**_____

**Phone number:** _____ **Approved Dates of Service:**_____

**I/we will be paying for lessons. I agree to pay for lessons at BITS by one of the following methods (please check one):**

❒ Payment In Advance ❒ Payment by Credit Card

❒ Pay As You Go ❒ Agency Award

*I acknowledge that I have read and understand BITS of Freedom's Cancellation and Payment Policies.*

**Signature**_____ **Date**_____

For Automatic Credit Card Charges to Mastercard, Visa or Discover

CC#_____CCV_____ Expiration Date_____

Signature_____ Date_____

# BITS of Freedom
## Therapeutic Riding Center

8180 Even Rd. Beulah, Colorado 81023
~ Phone: 719-369-9756

**2020 Lesson Rates**

| Term/Semester | Private | | | Group | |
|---|---|---|---|---|---|
| | ***1 hr*** | ***45 min.*** | ***30 min.*** | ***1 hr*** | ***45 min.*** |
| No winter available yet | | | | | |
| **Spring Semester 6 Weeks** | $300.00 | $300.00 | $250.00 | $300.00 | $300.00 |
| **Summer Term 6 weeks** | $300.00 | $300.00 | $250.00 | $300.00 | $300.00 |
| **Fall Semester 6 weeks** | $300.00 | $300.00 | $250.00 | $300.00 | $300.00 |

We charge $40.00 for all initial assessments. This will be included on the first bill for services.

Lesson Holidays: January 1st, Memorial Day, July 4th, Labor Day, Thanksgiving, the Friday and Saturday following Thanksgiving, Christmas (or the observed federal holidays when they fall on weekends)

Please refer to our website for a complete listing of Term/Semester start and end dates.

# *NEW* CLIENTS
## **BITS of Freedom** Therapeutic Riding Center
## wants to get to know you!

BITS of Freedom (BITS) we want your time with us to be as successful as possible. We are asking you to fill out this form for you/your child to let our instructors and volunteers know what they can do to make this a positive experience for you from the start. This information will only be shared with our staff and volunteers who work directly with you/your child. If you have any concerns about this form, please contact us.

Name:_____ Nickname: _____

Communication (style, understanding/comprehensive and ability to express needs):_____

_____

_____

Best Learning Style(s):

☐ Visual/Learns by Seeing ☐ Verbal/Learns by Hearing ☐ Kinesthetic/Learns by Doing

Favorites: (eg: food, colors, animals, subjects, etc)_____

_____

_____

Sensitivities: (eg: smell, touch, sounds, etc.)_____

_____

_____

Our Family's Do's and Don'ts:_____

_____

_____

Any other special things we should know?_____

_____

_____

Thank you for taking the time to fill out one more piece of paperwork!!