



Dear New Student/Family/Caregiver,

Thank you for your interest in Hearts Therapeutic Equestrian Center, a non-profit dedicated to enhancing the capabilities of children and adults with special needs in the Tri-county area since 1985.

HEARTS is proud to provide the industry's best practices in Equine Assisted Activities and Therapies as a Premiere Accredited Center with PATH International (Professional Association of Therapeutic Horsemanship).

Hearts Therapeutic strives to keep our fees as low as possible as a service to our riders, while maintaining the optimum health of our horses and the provision of safe professional services. As a result, Rider tuition only covers 30 % of the actual cost of each lesson. The remaining cost is funded through donations, grants and fundraising events to ensure an affordable program for each Rider.

Hearts' mission is to serve people with disabilities. We also accommodate riders without disabilities in a limited number of classes. Persons with disabilities are always given priority when space is limited, and are the sole recipients of scholarship assistance.

All rider applications must be completed, signed and dated as indicated, and submitted prior to booking an assessment. The applicant will receive communication from the HEARTS office to schedule an assessment once the completed application has been received and reviewed by our Certified Therapeutic Riding Instructors. Assessments will determine the suitability of the applicant and the best placement for the rider in the HEARTS program.

We look forward to serving you.

Sincerely,

Devon Sachey  
Program Director  
Hearts Therapeutic Equestrian Center  
devon@heartsridding.org



## Contact Information

For Questions Regarding Paperwork and Scheduling, and to return your New Rider Paperwork please contact:

**Shallon Dusebout, Program Coordinator**

[shallon@heartsriding.org](mailto:shallon@heartsriding.org)

Office: 805-964-1519

Fax: 805-967-6365

For Questions Regarding Billing, please contact:

**Devon Sachey, Program Director**

[devon@heartsriding.org](mailto:devon@heartsriding.org)

Office: 805-964-1519

Fax: 805-967-6365

For Lesson Cancellations, please contact the main office and/or your instructor:

Office: 805-964-1519

Instructors:

Shallon Dusebout – [shallon@heartsriding.org](mailto:shallon@heartsriding.org)

Devon Sachey – [devon@heartsriding.org](mailto:devon@heartsriding.org)

Susan Weber – [susanweber2@gmail.com](mailto:susanweber2@gmail.com)

Darcie Simson – [darcieucsb00@hotmail.com](mailto:darcieucsb00@hotmail.com)

Thom Bateman – [thom1946@gmail.com](mailto:thom1946@gmail.com)



## Billing Information

Students are enrolled at Hearts on an annual basis and assume responsibility for the full tuition of the months in which they are enrolled. Riders who enroll at Hearts will be automatically billed through the auto-billing system. Please complete the following Credit Card Authorization Form.

Hearts will deliver 46 weeks of riding in 2016. To establish monthly fees, tuition for 46 weekly lessons was pro-rated across 12 months of the year. Therefore, monthly tuition remains consistent throughout the year, regardless of when any lesson breaks occur.

## Fees

- Group Lesson Tuition \$240 per month
- Private Lesson Tuition \$320 per month
- Registration fee \$50 one-time fee, due with first month tuition

## Tuition Agreement

**NO make-up lessons or refunds will be provided**

Preparation for each lesson requires scheduling Horses, Volunteers, Instructors, curriculum development, and financial support. Hearts secures these valuable resources in anticipation of every lesson and is therefore unable to provide a refund or make-up lesson should a rider cancel or not show.

Hearts is also committed to providing therapeutic lessons, mounted or unmounted, despite inclement weather, and will NOT cancel lessons unless there is lightning, flood, or sever weather. Should Participants have any questions as to whether Hearts is open for lessons due to holiday, inclement weather or otherwise, call the office at (805) 964-1519.

Adjustments to tuition will be negotiated on an individual basis in the case of extended, unexpected medical conditions that prevent riding. Financial assistance may be available for therapeutic riders only. Please contact the office for details.

Participants MUST provide written notice to discontinue participation in the Hearts Riding Program no later than **30 days prior** to the next billing cycle. Should a participant wish to place their tuition on hold for anticipated absences, Hearts will require **30 days** written notice and a **\$75 hold fee** for each month a participant will be absent from the Program.

*The signature of the financially responsible party below signifies an understanding of and agreement to pay tuition according to the guidelines listed above.*

Rider's Name \_\_\_\_\_ Email Address: \_\_\_\_\_

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_



**AUTOMATIC BILLING AUTHORIZATION**

**Name on Card:** \_\_\_\_\_

**Billing Address:** \_\_\_\_\_

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

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Participant's Name:** \_\_\_\_\_

I hereby authorize Hearts Therapeutic Equestrian Center to charge my card on the 10<sup>th</sup> of each month for the following amount:

<b>Group Lesson</b>	\$240.00 _____	<b>Private Lesson</b>	\$320.00 _____
<b>One-Time Registration Fee</b>	\$50.00 _____	<b>Lesson Hold Fee</b>	\$75.00 _____
<b>Other</b>	\$ _____		

**Credit Card:** \_\_\_\_\_ **Expiration:** \_\_\_\_\_ **Code:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Email, fax, or drop off your automatic billing form to:  
Hearts Therapeutic Equestrian Center  
4420 Calle Real Rd.  
Santa Barbara, CA 93111  
Phone: 805.964.1519  
Fax: 805.967.6365  
devon@heartsridding.org

<p><i>For Office Use Only</i></p> <p>Participant Start Date:</p>
--



## Participant Application & Health History

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

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

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

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_ Alternative #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Legal Guardian/Caregiver: \_\_\_\_\_

How did you hear about our program: \_\_\_\_\_

Previous horse/riding experience: \_\_\_\_\_

### Rider Health History

Primary Diagnosis: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Secondary: \_\_\_\_\_ Date of onset: \_\_\_\_\_

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

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/joint			
Muscular			
Thinking/Cognition			
Allergies			

**Medications** (include prescription and over the counter, name, dose and frequency):

---



---



---



---



**Please describe your abilities/difficulties in the following areas**

**Physical Function**

Mobility skills, assistance required or equipment needed, i.e. transfers, walking, wheelchair, driving/bus riding etc.

---

---

---

**Psycho/social Function**

Work or school environment (grade completed), leisure interests, relationships/family structure, support systems, companion animals, fears, anxieties, concerns, etc.

---

---

---

**General Goals: Why are you applying for participation? What would you like to accomplish?**

Examples: Improved confidence, balance, speech, endurance, posture, focus, social development, etc.

---

---

---

**Life Goals: What would you like to improve in your everyday life?**

Examples: Ride a bike, make a friend, develop coping skills for anxiety, appropriate behavior, etc.

---

---

---

**Signature:** \_\_\_\_\_

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



**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

In the event emergency treatment / aid is required due to illness or injury during the process of receiving services, or being on the property of the agency, I authorize *Hearts Therapeutic Equestrian Center* to:

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

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

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

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

**In the event of an emergency, contact:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

**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 listed below is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

*Client, Parent, or 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: \_\_\_\_\_

*Client, Parent, or Guardian*



Dear Health Care Provider:

Your patient is interested in participation in supervised equine assisted activities and therapies at Hearts Therapeutic Equestrian Center. In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Medications (type, purpose, & dose): \_\_\_\_\_

If Down Syndrome, Atlanto-Axial Subluxation? Yes \_\_\_\_\_ No \_\_\_\_\_

All students with Downs Syndrome must have written, signed documentation as a result of a neurological exam.

Results: Positive \_\_\_\_\_ Negative \_\_\_\_\_ Exam date: \_\_\_\_\_

Tetanus Shot: Yes \_\_\_\_\_ No \_\_\_\_\_ Date: \_\_\_\_\_

Please note that the following conditions may suggest precautions and contraindications to equine assisted activities and therapies. Therefore, when completing the form, please note whether these conditions are present, and to what degree.

**Orthopedic**

- Atlantoaxial Instability (include neurologic symptoms)
- Coxa Arthrosis
- Cranial Defects
- Heterotopic Ossification/Myositis Ossifications
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Join Fusion/Fixation
- Spinal Joint Instability/Abnormalities

**Neurologic**

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

**Other**

- Age- under 4 years
- Indwelling Catheters
- Medications- i.e. photosensitivity
- Poor Endurance/Skin Breakdown

**Medical/Psychological**

- Allergies
- Animal Abuse
- Cardiac Condition
- Hemophilia
- Migraines
- Fire Setting
- PVD
- Recent Surgeries
- Substance Abuse
- Respiratory Compromise
- Thought Control Disorders
- Weight Control Disorders
- Medical Instability
- Blood Pressure control
- Dangerous to self or others
- Exacerbations of medical conditions (i.e. RA, MS)
- Physical/Sexual/Emotional Abuse





**Participant Medical History**  
*to be completed by Physician*

<b>PROBLEM</b>	<b>YES</b>	<b>NO</b>	<b>IF YES, DESCRIBE</b>
AUDITORY IMPAIRMENT	_____	_____	_____
LEARNING DISABILITY	_____	_____	_____
MENTAL IMPAIRMENT	_____	_____	_____
PSYCHOLOGICAL IMPAIRMENT	_____	_____	_____
SPEECH IMPAIRMENT	_____	_____	_____
VISUAL IMPAIRMENT	_____	_____	Glasses: _____
ALLERGIES	_____	_____	_____
CARDIAC	_____	_____	_____
CIRCULATORY	_____	_____	_____
PVD	_____	_____	_____
Postural Hypotension	_____	_____	_____
Hemophilia	_____	_____	_____
PULMONARY	_____	_____	_____
Asthma / COPD	_____	_____	_____
NEUROLOGICAL	_____	_____	_____
Seizures	_____	_____	_____
Controlled?	_____	_____	Type: _____
Last Seizure:	_____	_____	_____ / _____ / _____
Hydrocephalus	_____	_____	_____
Shunt	_____	_____	# Revisions: _____
Sensory Loss	_____	_____	_____
Pain	_____	_____	_____
MUSCULAR	_____	_____	_____
Contractures	_____	_____	_____
SKELETAL	_____	_____	_____
Spinal Column Injury	_____	_____	_____
Subluxing Joints	_____	_____	_____
Dislocating Joints	_____	_____	_____
Laminectomy / Fusion	_____	_____	_____





## Participant's Consent for Release of Information

I hereby authorize: \_\_\_\_\_  
(Physician, person or facility)

to release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Participant's name)

The information is to be released to: \_\_\_\_\_  
HEARTS THERAPEUTIC EQUESTRIAN CENTER  
(PATH International Therapeutic Center)

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- Medical history
- Physical therapy evaluation, assessment and program plan
- Speech therapy evaluation, assessment and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (IHP) Classroom
- Individual Education Plan (IEP) Psychosocial
- evaluation, assessment and program plan Cognitive-
- behavioral management plan
- Other: \_\_\_\_\_

This release is valid for one year and can be revoked, in writing, at my request.

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

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

Relation to Participant: \_\_\_\_\_

Please send materials to: \_\_\_\_\_  
HEARTS THERAPEUTIC EQUESTRIAN CENTER  
\_\_\_\_\_  
P.O. Box 30662  
\_\_\_\_\_  
Santa Barbara, CA 93130  
\_\_\_\_\_  
OR Fax: 805-967-6365  
\_\_\_\_\_



**Waiver and Release of Liability**

**Name:** \_\_\_\_\_

**Program Participant** (if under 18): \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

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

I acknowledge that horseback riding or activities involving horses is an extreme test of a person’s physical and mental limits and carries with it the potential for serious injury, personal property loss or even death. Horses are large animals and even the gentlest horse can be unpredictable. I hereby assume the risk of participating in such activities.

I hereby take the following action for myself and my executors, administrators, heirs, next of kin, successors and assigns:

- a) I waive, release and discharge from any and all claims or liabilities for death, personal injury or damages of any kinds, which acts arise out of or relate to my participation in, or my traveling to and from, the horseback riding events, the following persons or entities: Hearts Therapeutic Equestrian Center, building or facility lessees, sponsors, and the officers, directors, employees, representatives, instructors and agents of the above.
- b) I agree not to sue any of the persons or entities mentioned above for any of the claims or liabilities that I have waived, released or discharged herein, and
- c) I indemnify and hold harmless the persons or entities mentioned above from any claims made or liabilities assessed against them as results of my actions and any attorney fees or costs incurred by them as a result of my action.

**Photo Release:**

I hereby consent to and authorize the following, OR

I do not consent to, nor do I authorize:

Hearts Therapeutic Equestrian Center’s use and reproduction of any and all photographs and other audiovisual material taken of me for promotional printed materials, social media, educational activities, exhibitions, or for any other use for the benefit of the program.

**Confidentiality Agreement:**

I understand that all information (written and verbal) about participants at this PATH center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

*By signing this form, I affirm that I am eighteen (18) years of age or older, I have read this document, and I understand its contents.*

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