ALBANY THERAPEUTIC RIDING CENTER, INC.
founded 1981

Albany Therapeutic Riding Center, Inc.
6640 Fuller Station Road,
Altamont, New York 12009
(518) 898-0742
albanytherapeuticridingcenter@gmail.com

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Professional Association of Therapeutic Horsemanship International

PARTICIPANT APPLICATION AND HEALTH HISTORY

(To be completed by the participant or parent/ legal guardian)

Today's Date:_____/_____/_____

PARTICIPANT INFORMATION

Name:_____ Nickname:_____ Age:_____

DOB:_____ Height:_____ Weight:_____Gender Identity:_____

Primary Diagnosis:_____ Secondary Diagnosis:_____

Date of Onset:_____

Who does participant live with? (Self, parent/ guardian, home program provider, etc.)_____

Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

How did you hear about the program? _____

Is the participant interested in: _____ Riding _____ Ground Program (**weight limit for riding: 200lbs**)

Participant _____ **is** _____ **is NOT** able to sit independently

CONTACT INFORMATION

Parent/ Legal Guardian (*if different from participant):*_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Day Program Provider (*if different from parent/ guardian)*:_____

Home Phone:_____ Cell Phone:_____

Email:_____

In the event of any emergency and the parent/ guardian is not available, please contact:

Name:_____ Relationship:_____ Phone:_____

Participant or Guardian Employer/ School:_____

Address:_____ City:_____ State:_____ Zip:_____

BILLING INFORMATION (*if different from parent/ guardian)*

Name:_____ Organization:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____

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MEDICATIONS (*include prescription, over the counter; name, dose and frequency)* Attach additional sheet if needed)

_____
_____
_____

Please provide additional information in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (*i.e. mobility skills such as transfers, walking, wheelchair use, driving/ bus riding)*

_____
_____
_____
_____

PSYCHO/ SOCIAL FUNCTION *(i.e. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/ concerns, etc.)*

_____
_____
_____
_____

DESCRIBE PARTICIPANT'S PREVIOUS RIDING EXPERIENCE/ CURRENT LEVEL OF RIDING:

_____
_____
_____

DESCRIBE HORSEBACK RIDING GOALS:

_____
_____
_____

SPECIFIC PHYSICAL, COGNITIVE, AND/ OR EMOTIONAL GOALS:

_____
_____
_____

Is there anything that would be helpful for the instructors or volunteers to know about the participant or their learning style?

_____
_____
_____

Signature:_____ Date:_____

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THERAPEUTIC RIDING AND GROUND PROGRAM FEES

A $30 non-refundable administration fee is due with participant application paperwork. This fee is due at the time the completed application is submitted. ATRC accepts cash, checks, or PayPal payments for all fees, session fees must be paid in full the week before a session begins. **(paypal.me/albanyTRC) (Venmo: albanytherapeuticridingcenter1)**

All applications will be reviewed and considered for an hour or half hour private lesson, a select few applications will be considered for group lessons **at the discretion of the instructor.** Please be prepared for your rider to start their lessons with ATRC as a private, one on one mounted or unmounted session.

Groups will be either an hour or a half hour and will consist of 2-5 riders. If you believe group lessons would help meet specific goals of your rider, let us know and we will evaluate/ schedule groups based on age, riding skill level, and goals/ objectives. (Groups will be CAREFULLY matched, and group structure and group placement will be determined by the instructor. Just because you are interested in a group does not guarantee you a group slot, as the group environment may not be appropriate for certain riders).

After the completed paperwork and administrative fee has been received, ATRC will be in touch to confirm receipt and advise the next steps towards the evaluation/ intake assessment. **The intake has a $30 fee as well**.

SESSION 1 (6 weeks)

Dates: Jan. 6th- Feb. 16th

Off Week: 2/17-2/23

SESSION 2 (6 weeks)

Dates: Feb 24th- Apr. 6th

Off Week: 4/7-4/13

SESSION 3 (6 weeks)

Dates: April 14th- May 25th

Off Week: 5/26-6/1

SESSION 4 (6 weeks)

Dates: June 2nd-July 13th

Off Week #1: 7/14-7/20

Off Week #2: 7/21-7/27

Session Fees (6 week sessions)

Therapeutic Riding	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
Private Hour ($65/hr)	$390	$390	$390	$390	$390	$390
Private Half Hour ($50/half hour)	$300	$300	$300	$300	$300	$300
Group Hour ($65/ rider/hour)	$390	$390	$390	$390	$390	$390
Group Half Hour ($50/hour/rider)	$300	$300	$300	$300	$300	$300
Ground Program- Equine Assisted Learning: Half hour private ($50/ half hour)	$300	$300	$300	$300	$300	$300
GP- EAL Group Half Hour ($50/ rider/half hour)	$300	$300	$300	$300	$300	$300

*Intake assessments $30/half hour scheduled during registration week

SESSION 5 (6 week)

Dates: July 28th-Sept. 7th

Off Week: 9/8-9/14

Session 6 (6 weeks)

Dates: Sept. 15th- Oct. 26th

Off Week: 10/27-11/2

Session 7 (6 weeks)

Dates:Nov 3rd-Dec. 14th

Off Weeks: Dec. 15th-?

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PARTICIPANT AVAILABILITY

Participant Name:_____ Date:_____/_____/_____

Please indicate all available times for riding or ground program lessons: (*please note lessons are held on a weekly basis, so this must be a time the participant is available every week for at least 6 weeks- No lessons are held on Saturdays at this time).*

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
9:00am	X						
9:30am	X						
10:00am	X						
10:30am	X						
11:00am	X						
11:30am	X						
12:00pm	X						
12:30pm	X						
1:00pm	X						
1:30pm	X						
2:00pm	X						
2:30pm	X						
3:00pm	X						
3:30pm	X						
4:00pm	X						
4:30pm	X						
5:00pm	X						
5:30pm	X						
6:oopm	X						
6:30pm	X						

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ATRC Cancellation Policy

Albany Therapeutic Riding Center, Inc. is putting the following lesson cancellation policies into effect immediately:

1) We ask that if you need to cancel a lesson, please inform your instructor **at least 24 hours** prior to your scheduled lesson time. Your lessons will resume normally in the following week. If you would like to plan a make-up lesson at a different date or time, we will try our best to accommodate you. One make-up lesson is allowed per session. Please understand that the make-up lesson is contingent on instructor and volunteer availability. Any lessons canceled by the rider through a session that have not been made up by the end of a session will not be credited or refunded.

2) If you cancel a lesson less than 24 hours of your scheduled lesson time, you will be charged a late cancellation / no show fee which is equivalent to the price of an individual lesson. The 24 hour window does **NOT** apply in the event of an emergency situation or inclement weather. This advanced notice allows us to use the now free time effectively - to organize make-up lessons for other students, to plan a volunteer training session, etc.

3) In the event that severe weather is being forecasted, i.e. severe thunderstorms, tornados, blizzards, etc, and the **Staff at ATRC decide to make the call to cancel**, there will be NO penalty to any rider, as it was the Program's decision to cancel. We will notify you as soon as we can of Program cancellations. Lessons canceled by ATRC will have priority for make up lessons. If no make up lesson spaces are available, prepaid left over lessons will be credited to the next session, only in the case that ATRC makes the cancellation. **ATRC does not hold mounted riding lessons in the event that the temperature or "real feel" is above 90 degrees Fahrenheit or below 20 degrees Fahrenheit for the safety of all horses and humans.** ATCR will instead provide unmounted horsemanship lessons in place if weather permits.

4) As always, these policies are subject to change as the Riding Center grows and expands! We want to bring as much communication to the front with all our riders, volunteers, and Staff members that we can. Thank you for your understanding!

Office Phone: (518) 898-0742 Taylor's Email: albanytherapeuticridingcenter@gmail.com

Kate Carlson- Herba: carlsonk@albanytherapeuticridingcenter.com

Lindsey Scaparo: scaparoL@albanytherapeuticridingcenter.com

Jocelin Biss: bissj@albanytherapeuticridingcenter.com

Participant Signature: Date:_____

(Parent or Guardian signature if participant is under 18)

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Emergency Medical Treatment Authorization Form

Name_____DOB_____Phone_____
Address_____
Physician's Name, Town, Phone_____
Health Insurance Company _____Policy #_____
Allergies to medication_____
Current medications and
dosage_____
_____

Caregiver Information: Name _____
Phone_____
Cell phone number_____
Address (if different than above)_____

In the event of an emergency, contact:

Name_____ Relationship_____ 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 Albany Therapeutic Riding Center, Inc. , I authorize Albany Therapeutic Riding Center, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release my medical, lesson 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 none of the persons listed above are unable to be reached.

Date_____ Consent Signature_____

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Records Access Authorization

TO WHOM IT MAY CONCERN:

Pursuant to the regulations under HIPAA, this memorandum is authority for you to provide to Albany Therapeutic Riding Center, Inc. or their authorized representative, all medical records, psychiatric records, hospital records, x-rays, technician's reports, pharmacy or drugstore records, medical charts, offices notes, physicians reports, or other medical information related to the examination and treatment of (name of participant).

I, _____ (name of participant, parent or natural guardian), understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, would then no longer be protected by federal privacy regulations.

I, _____(name of participant, parent or natural guardian), may revoke this authorization by notifying Albany Therapeutic Riding Center, Inc. in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

A photocopy of this authorization may be accepted with the same force and effect as an original. This authorization expires on December 31, 2025, or at such time when participant completes 2025 programming.

Dated:_____ Signature of participant/guardian_____
DOB:_____ State of New York, County: _____

On this day of _____, before me personally came and appeared to me known and known to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she/he/they executed the same.

Possible Reasons for Client Discharge

Please be advised of the following reasons that may lead to discharge from the program.

1. Client has reached all of their goals!
2. Client displays a condition listed by PATH as a contraindication to therapeutic riding.
3. Client's potential to maintain head and neck control in sitting position presents a safety concern.
4. Inability to follow directions is interfering with progress toward treatment goals.
5. Uncontrolled and inappropriate behavior that constitutes a safety risk to client, volunteer or staff.
6. Client exceeds weight limit that can safely be managed by staff, volunteers and/or horses (**Current Weight Limit for Mounted Activities: 200lbs**).
7. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding or hippotherapy inappropriate.
8. Three scheduled sessions are missed without proper canceling.
9. Nonpayment of billed funds after **first (1st) lesson of each session.**

Signature of Client or Legal Guardian:_____ **Date:**_____

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Photo Release

I, _____ **consent** to and authorize the use and reproduction by Albany Therapeutic Riding Center, Inc. and its representatives of any and all photographs and any other audiovisual materials taken of me and/or my child for promotional material, educational activities, exhibitions or for any other use for the benefit of Albany Therapeutic Riding Center, Inc. including use on the Albany Therapeutic Riding Center, Inc. Facebook and Instagram accounts.

Signature _____ Date _____

Print Name and Relationship to Participant_____

Confidentiality Agreement

I understand that all information (written and verbal) about participants and Albany Therapeutic Riding Center, Inc.'s program is confidential and will not be shared with anyone without the express written consent of the participant and his/her/their guardian in the case of a minor.

Signature_____Date_____

Safety Standards

- ☐ Walk while on the property
- ☐ Be gentle with animals and people
- ☐ No fighting or abusive/aggressive actions
- ☐ No throwing objects
- ☐ No fires AND no smoking
- ☐ No weapons (guns, knives, etc.), alcohol, or other illegal substances on the property
- ☐ Children must be supervised by an adult at all times
- ☐ No personal pets on the property
- ☐ Respect "Off Limits," "Authorized Personnel only," and paddock and private residence areas
- ☐ Do not enter stalls, paddocks, or pastures without first notifying a staff member.

In signing this document I, _____, agree to abide by the Safety Standards that are detailed above.

Signature: _____Date:_____

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RELEASE AND WAIVER OF LIABILITY

My full name is:_____

My child or ward's full name (if applicable) is:_____

Child/ward's date of birth (Month/ Day/ Year):_____

Please check one: I would like **myself_____** or **my child or ward_____**(the "participant") to engage in horseback riding an equine assisted activities and/or to volunteer to aid riders who are participating in equine assisted activities, which includes all activities of any nature whatsoever in conjunction with the use and enjoyment of horses, whether or not mounted, and any equipment utilized or demonstrated, all of which is defined as this "Activity."

I reside at: [Street]_____

[City/ State/ Zip]_____

In the event of an emergency, please contact:

1. Name:_____
   a. Relation:_____
   b. Phone:_____
2. Name:_____
   a. Relation:_____
   b. Phone:_____

In consideration for participating in this Activity, as offered by Albany Therapeutic Riding Center, Inc., I, as the Participant and in the case that the Participant is a minor or incompetent adult, as the Participant's parent (the "Parent") or legal guardian (the "Guardian") hereby, on behalf of the Participant and the Undersigned, and their respective wards, personal representatives, executors, administrators, heirs, next-of-kin, spouses and assigns, acknowledge and agree as follows:

1.Acknowledge that this Activity is a potentially dangerous activity and involves numerous obvious and non-obvious inherent risks that may cause serious injury, and in some cases, death because of the sometimes unpredictable nature and irrational behavior of horses regardless of their training and past performance;

2.Acknowledge that this Activity is instructional and not recreational and therefore foes not fall within the scope of the New York General Obligations Law, § 5-326;

3.Certify that the Participant is capable of participating in this Activity and acknowledge that the undersigned Participant, Parent and/ or Guardian voluntarily assumes the risk and danger of loss, injury, accident, illness, paralysis, loss of personal property, or death and expenses resulting from this Activity or the use of the horses, equipment, and gear provided to the Participant for this Activity;

4.Acknowledge and agree that the Participant who is engaged in and Albany Therapeutic Riding Center, Inc. activity will wear a safety helmet that meets or exceeds the equestrian industry standard; additionally, if the helmet is provided by the Participant, the helmet will meet the above standard;

5.Expressly WAIVE any claim lawsuit, complaint, charge, or cause of action against Albany Therapeutic Riding Center, Inc., its agents, therapists, board of directors, aides, employees, officers, volunteers, and affiliated organizations by the Participant, Parent and/ or Guardian, as applicable, for any loss, legal liability, damages or costs

whatsoever arising out of or related to any loss, injury, accident, illness, paralysis, loss of personal property, or death to the Participant, and to other persons as a result of the Participant's participation, including medical expenses, in this Activity;

6. RELEASE Albany Therapeutic Riding Center, Inc .from any claim that Albany Therapeutic Riding Center, Inc. was negligent in connection with the Participant's participation in this Activity, including but not limited to, training or selecting horses, maintenance, care, fit or adjustment of saddles or bridles, instruction on riding skills or leading and supervising riders or the use of equipment provided by Albany Therapeutic Riding Center, Inc. or being on the premises on which Albany Therapeutic Riding Center, Inc. operates, which result in loss, damage, injury or death;

7. INDEMNIFY AND SAVE AND HOLD HARMLESS Albany Therapeutic Riding Center, Inc. from and against any loss liability, damage or cost Albany Therapeutic Riding Center, Inc. may incur arising out of or in any way connected with the Participant's handling or riding a horse and/ or use of saddles, bridles, equipment, and gear provided therewith from or contributed to by the Participant's or Undersigned's own negligence; and

8. Expressly AGREE that this Release and Waiver of Liability is governed by the State of New York and is intended to be as broad and inclusive as is permitted by New York law, and that in the event any portion of this Release and Waiver of Liability is determined to be invalid, illegal, or unenforceable, the validity, legality, and enforceability of the remainder of this Release and Waiver of Liability shall continue in full legal force and effect.

I, the Undersigned, have read this Release and Waiver Agreement and understand that by signing this document, I am waiving valuable rights and/ or claims that I may have against Albany Therapeutic Riding Center, Inc.

The Undersigned:

I am 18 years of age or older and am competent to contract in my own name. I have read this Release and Waiver of Liability before signing below and I fully understand its contents, meaning, and impact.

PARTICIPANT:

Signature:_____ Date:_____

Name of Signatory (please print):_____

If Participant is age seventeen or younger, or an incompetent adult, there must be consent by a parent or guardian as follows: I hereby certify that I am the Parent or Guardian of the Participant named above and am signing below as an individual and in my capacity as the Parent or Guardian of the Participant and hereby give my consent without reservation to the foregoing on behalf of the Participant.

Parent or Legal Guardian Signature:_____ Date:_____

Name of Signatory (please print):_____

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MENTAL HEALTH INFORMATION

(To be completed by participant, parent, or guardian and/or Mental Health Provider)

Treatment Coordinator/ Therapist:_____

Organization:_____ Phone:_____

Presenting Problems:_____

_____

Current Diagnoses:_____

Past Diagnoses:_____

Current Psychiatric Medications:_____

Please check if any of the following are present:

- Anxiety
- Depression
- ADHD
- Aggression
- Poor impulse control
- Hearing Voices/ other hallucinations
- History of experiencing physical, emotional, or psychological abuse
- History of committing physical, emotional, or psychological abuse
- Autism Spectrum Disorder
- Developmental Disability
- Severe mood swings
- Sensory Processing Disorder
- History of substance abuse
- Schizophrenia- spectrum disorder
- Other mood disorder
- Dementia or Alzheimer's
- Other

Will any of the above (or anything not listed) have limitations on your participation in this program? Yes / No

If yes, please describe: _____

_____

Briefly describe any checked boxes:_____

_____

What are some symptoms we should be aware of?_____

_____

To my knowledge, the information on ALL of the above forms is complete and accurate.

Date:_____ **Signature:**_____

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Medical History & Physician's Statement

(Must be completed by physician)

Date_____

Dear Physician:_____
Your patient,_____ is interested in participating in supervised equestrian activities.
(participant's name)
In order to safely provide this service, Albany Therapeutic Riding Center, Inc. requires that you complete the attached Medical History and Physicians Statement Form. Please note that the following conditions may suggest precautions and contraindication to therapeutic horseback riding. Therefore, when completing these forms, please note whether the conditions are present and to what degree.

Weight _____Height_____ DOB _____
Diagnosis_____ Date of Onset _____
Past/Prospective Surgeries_____
Medications_____
Seizure type_____
Controlled: Y N Date of last seizure_____
Shunt present: Y N Date of last revision_____
Date of last Hip Radiograph_____ Result (please describe)_____
Special precautions/needs _____
_____
Mobility:

Independent Ambulation	Y	N
Assisted Ambulation	Y	N
Wheelchair	Y	N

Braces/assistive devices_____
For those with Down Syndrome:
Atlanto Dens X-Rays, date_____ Result: + -
Neurologic symptoms of AtlantoAxial Instability_____
_____

What physical, cognitive and/or emotional goals do you have for this participant?
_____
_____

Is the any further information that you think Albany Therapeutic Riding Center, Inc. should know regarding the medical condition of this individual?

_____
_____
_____

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Patient's Name:_____

Please indicate whether these conditions are present, and to what degree. Please attach any necessary additional information.

Orthopedic
____Atlantoaxial instability-include neurologic symptoms
____Coxa Arthrosis
____Cranial Defects
____Heterotropic ossification/ Myositis Ossificans
____Joint subluxation/dislocation
____Osteoporosis
____Pathologic fractures
____Spinal fusion/fixation
____Spinal instabilities/abnormalities

Medical/Psychological
____Allergies
____Animal abuse
____Physical/ Sexual/ Emotional Abuse
____Blood pressure control
____Dangerous to self or others
____Exacerbations of medical conditions
____Fire Settings
____Heart conditions
____Hemophilia
____Medical Instability
____Migraines
____PVD
____Respiratory Compromise
____Recent surgeries
____Substance abuse
____Thought control disorder
____ Varicose veins
____Weight control disorder

Neurologic
____Hydrocephalus/shunt
____Seizure
____Spina Bifida
____Chiari II malformation
____Tethered cord
____Hydromyelia

Other
____Age-under 4 years
____Indwelling catheters
____Medications
i.e. photosensitivities
____Poor endurance
____Skin breakdown

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Please indicate current or past difficulties in the following systems/arena, including surgeries:	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

After careful review of _____ (participant's name)'s medical history and consideration of the risks of equestrian activities, to my knowledge, there is no reason why this person cannot participate in supervised equestrian activities.

Printed Name_____ Title_____
Signature_____ Date_____
Phone_____
Address_____
License/UPIN Number_____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equestrian activities, please feel free to contact our Executive Director, Taylor Huntley via email (albanytherapeuticridingcenter@gmail.com).

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[Practitioner to fill this form out if participant is receiving services]

Dear Physical/Occupational therapist:

One of your clients is interested in therapeutic horseback riding lessons. Enclosed you will find an assessment form which will help our therapists and instructors develop a safe and effective riding program for him/her/them. Please fill out the areas that pertain to your expertise, and attach any existing assessments or reports that you feel will be helpful to our staff.

Please make special note of any precautions or contraindications to therapeutic equestrian activities.

Therapeutic riding is a unique and productive way to improve the quality of life for many children and adults with physical, cognitive or psychological challenges. Your participation in Albany Therapeutic Riding Center, Inc.'s programming is welcomed and encouraged. Please feel free to contact us if you would like more information. Thank you in advance for your assistance.

Sincerely,

Taylor Huntley
Executive Director
Albany Therapeutic Riding Center, Inc.

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THERAPY ASSESSMENT

(Please fill out applicable areas)

Name of client:_____ Date of Birth:_____
Diagnosis:_____

History of therapy interventions:
_____
_____

Please describe the following functional abilities:

Sitting Balance (head/trunk control, balance reaction, supports needed):_____
_____

ROM Limitations: _____
_____

Active/Functional extremity movement: _____
_____

Mobility (with/without assistive devices): _____
_____

Sensory Systems:_____
_____

Equipment (when first used, purpose, present use):_____
_____

Communication methods used:_____
_____

Present primary therapy goals:_____
_____

Precautions and/or contraindications:_____
_____

Signature & Title:_____ Date: _____
Therapist's name (print):_____ Phone:_____
School, Center, Organization:_____ Phone:_____
Address_____ City_____ Zip:_____