CHEFF THERAPEUTIC RIDING CENTER
CHEFF THERAPY SERVICES

WELCOME TO CHEFF CENTER

PLEASE READ (AND KEEP) THE FOLLOWING GENERAL INFORMATION AND GUIDELINES:

- **Paperwork:** All forms must be completed and signed prior to your initial assessment, *including our Physician Consent form signed by a doctor.* In addition, a physician's referral is required for all patients receiving hippotherapy.
- **Payment:** in full is expected **BEFORE** the start of each therapeutic riding session. We bill by the session-not by the week. **No credits are given unless Cheff cancels classes.**
- **Classes:** run back-to-back during our busiest days. Please make every effort to be on time. **If you arrive more than 15 minutes late you will forfeit your ride that day.**
- **General Guidelines:**
  - Family members are welcome to observe lessons/therapy sessions. Our lobby has a viewing area to the arena for your comfort.
  - Please leave your pets at home: certified service animals ARE allowed.
- **Contact** Cheff at 269-731-4471, ext 120 or email jane@cheffcenter.org to sign up for an assessment and/or to answer any questions you may have.

DISCRIMINATION DISCLOSURE

It is the policy of the Cheff Therapeutic Riding Center to provide equal opportunity for all persons and to prohibit unlawful discrimination because of age, disability, race, color, creed, religion, gender, national origin, or veteran status. This policy applies to all participants, potential participants, volunteers, and employees.

APPROPRIATE BEHAVIOR

The safety of clients, volunteers, and staff is taken very seriously. Verbal and physically threatening behavior will not be tolerated. Cheff reserves the right to dismiss clients from the program based on this policy.

CANCELLATIONS

If Gull Lake Schools are closed DUE TO WEATHER, all lessons and treatments are automatically cancelled for that day.

Cheff Therapeutic Riding Center
Cheff Therapy Services

Participant Application & Health History

OFFICE USE ONLY

TR ___ Hippo PT ___ Hippo Ltr ___

Equi-Force _____

Sandi _____ Emily _____

GENERAL INFORMATION

Participant name _____ DOB _____ Age _____

Address _____

City _____ State ____ Zip _____ County _____

Gender: M F O Height _____ Weight _____*

**** 200-pound weight limit variable dependent upon ambulatory status, ROM, and discretion of instructor***

Race: *American Indian*_____ *Asian* _____ *Black/African American* _____
Caucasian _____ *Hispanic/Latino* _____ *Multi-Racial or Other* _____

This information is optional – for grant purposes only

Parent/Legal Guardian _____ Relationship _____

Address (if different from above) _____

Email Address _____

Phone-primary: _____ Phone-other (specify): _____

How did you hear about us?_____

HEALTH HISTORY (attach additional sheet if necessary)

Diagnosis/Disability _____

Other therapies currently received _____

Current medications _____

Psycho-social function (interests, family structure, support system, etc) _____

_____

Please mark any of the following that have been a recent or past issue and provide specific comments where applicable. These items will not be used to prevent anyone from participating; rather, they are to assist us in best meeting your needs:

- ☐ Mental health therapy _____
- ☐ Legal problems _____
- ☐ Grief/Loss _____
- ☐ Trauma _____
- ☐ Special assistance at school _____
- ☐ Substance abuse _____
- ☐ Family problems _____

Special assistance required (Cheff Center cannot provide these, but it helps us to plan classes/lessons)

- ☐ Sign interpretation _____
- ☐ Service dog assistance _____
- ☐ Wheelchair assist/transfer _____
- ☐ Visual assistance/aids _____
- ☐ Emotional/mental helper _____

Has the student had prior experience with therapeutic riding or hippotherapy? YES NO

If so, when and where? _____

Does the student…	**YES**	**NO**	**Comments**
Have a history of seizures?			
Follow simple directions?			
Have speech or language difficulties?			
Have communication difficulties?			
Have a fear of animals/horses?			
Walk independently?			
Have limited range of motion?			
Have decreased strength/endurance?			
Have poor balance (sitting/standing)?			
Have problems with gross motor skills?			
Have problems with fine motor skills?			
Have altered sensation? (specify)			
Have heart/circulation problems?			
Have digestion/elimination problems?			
Have bone/joint problems?			
Have allergies or breathing problems?			
Have emotional/behavioral problems?			

GOALS

What would you like to accomplish in our program? _____

_____

_____

_____

_____

_____

ADDITIONAL COMMENTS

Please provide any additional information that you feel would be helpful in class selection and lesson planning for this participant _____

_____

_____

_____

_____

_____

Please call the Cheff Therapeutic Riding Center at 269-731-4471 with any questions.

_____ _____

Participant signature Date

_____ _____

Parent/Guardian signature Date

Send completed forms to: **Cheff Therapeutic Riding Center, Attn Jane**
8450 North 43rd Street
Augusta MI 49012
jane@cheffcenter.org fax: 269-731-2990

Cheff Therapeutic Riding Center / Cheff Therapy Services
8450 North 43rd Street, Augusta MI 49012
Tel: 269-731-4471 Fax: 269-731-2990

Physician Consent Form

Participant's name: _____ DOB: _____
Parent/Guardian name: _____
Address: _____ City: _____ Zip: _____
Phone: _____ **CURRENT HEIGHT:** _____ **CURRENT WEIGHT:** _____

200-LB WEIGHT LIMIT DEPENDANT UPON AMBULATORY STATUS, ROM, AND THERAPIST DISCRETION

The Cheff Center is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possibly protection and greater personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a riding student.

NOTE: *BECAUSE OF THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL DIAGNOSED WITH DOWN SYNDROME CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT AN ANNUAL MEDICAL CLEARANCE FROM A LICENSED PHYSICIAN THAT INCLUDES A NEUROLOGIC EXAM THAT SPECIFICALLY DENIES ANY SYMPTOMS CONSISTENT WITH ATLANTOAXIAL INSTABILITY (AAI)*

Diagnosis: _____
_____ **Date of onset:** _____

IF DIAGNOSIS IS DOWN SYMDROME, THIS FORM MUST BE ACCOMPANIED BY A SIGNED AND DATED STATEMENT FROM THEIR PHYSICIAN THAT DENIES ANY SYMPTOMS CONSISTENT WITH AAI.

Does this person demonstrate explosive/violent behavior or the potential for explosive/violent behavior? _____ **If Yes, please explain:** _____
_____
_____

Medical History: _____
_____

Surgical Procedures: _____
_____

Medications: _____
_____

Deficits present in: ☐Sight ☐Hearing ☐Speech ☐Balance
☐Neuro-sensation ☐Muscle Tone ☐Coordination ☐Mobility

Braces or assisted devices used? ☐ NO ☐ YES: _____

Is the participant ambulatory? ☐ YES ☐ NO

Comment if applicable:
Seizures: _____
Incontinence: _____

General comments: _____

IN MY OPINION THE PATIENT NAMED ABOVE CAN RECEIVE RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION
Physician signature: _____ Date: _____
Physician's printed name: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Fax: _____

Cheff Therapeutic Riding Center / Cheff Therapy Services
8450 North 43rd Street, Augusta MI 49012
Tel: 269.731.4471 Fax: 269.731.2990

EMERGENCY TREATMENT RELEASE

Participant: _____ Date of birth: _____
Disability & date of onset: _____
Parent/Guardian: _____
Address _____
Street City State ZIP
Parent/Guardian's Employer: _____
Primary Email: _____Other Email: _____

Correspondence will be by Email. Do you prefer we contact you by phone instead?

☐ NO, email works fine for me ☐ YES, contact me via ph# below.

Primary Ph: _____ (who?) _____Other Ph: _____ (who?) _____

****

Physician's name: _____ Telephone: _____
Physician's address: _____
Health insurance provider: _____ Policy #: _____
Preferred medical facility: _____
Emergency contact (other than parent/guardian):
Name: _____ Relationship: _____
Phone(primary)_____ (other) _____
ALLERGIES: _____

DESCRIBE ANY MEDICAL CONDITIONS REQUIRING PRECAUTIONS/TREATMENT AND ANY MEDICATIONS WITH DOSAGE: _____
_____

____ I GIVE MY CONSENT: In case of a medical emergency, the undersigned authorizes the Cheff Therapeutic Riding Center to provide such medical assistance as they determine to be necessary. The undersigned authorizes any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the participant, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

OR

____ 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: _____
_____

No participant can be accepted for riding instruction until this form has been completed and signed. If the participant is of legal age (18), he or she may complete the form if he/she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned including the Cheff Therapeutic Riding Center.

SIGNATURE: _____ **DATE:** _____
(Participant if legally able or parent/guardian)

Cheff Therapeutic Riding Center / Cheff Therapy Services
8450 North 43rd Street, Augusta MI 49012
Tel: 269.731.4471 Fax: 269.731.2990

Liability & Photo Release Form

I agree to the following agreement with the CHEFF THERAPEUTIC RIDING CENTER, a Michigan nonprofit corporation (hereafter referred to as "Center") as a condition for allowing me, and the persons identified below, to enter the Center's premises and surrounding land, be near horses, participate in equine-assisted activities, work near horses, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance in riding, grooming, or handling of horses (these activities will hereafter be referred to in this document as "The Activities").

Participant if 18 or Parent/Guardian _____

Spouse or Other Parent _____

Home Address _____
Street City St ZIP

PHONE (Home)_____ (Business)_____ (Cell)_____

All parts of this agreement shall apply to the name(s) listed above. This Release is intended to be valid and binding at ***all times – now and in the future*** – when Center permits me (directly or indirectly) to engage in any or all of The Activities.

IT IS HEREBY AGREED AS FOLLOWS:

1. I have requested to engage in any or all of The Activities, now and/or in the future.
2. *Risks*. I understand that anyone engaging in The Activities can suffer bodily and other injuries. Participation in The Activities involved certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. **I understand the risks/dangers inherent in The Activities, and I agree to assume them. I am not relying on the Center to list all possible risks for me.**
3. *Waiver and Liability Release*. As consideration for Center allowing me to engage in The Activities at any time and at any location, I agree to assume full responsibility for any and all bodily injuries, losses, or damages that I may sustain. I, for my heirs, administrators, personal representatives, or assigns, release and discharge the CHEFF THERAPEUTIC RIDING CENTER, Cheff Therapy Services, and their employees, assistants, directors, volunteers, landowners, and owners of horses from any and all claims, demands, damages, actions, omissions, suits, or causes of action (present or future).

WARNING

Under the Michigan Equine Activity Liability Act [1994 P.A. 351], an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.

IT IS MUTUALLY UNDERSTOOD AND AGREED THAT THE WAIVER AND LIABILITY RELEASE SET FORTH IN THIS DOCUMENT CONSTITUTES A WAIVER OF LIABILITY BEYOND THE PROVISIONS OF THE MICHIGAN EQUINE ACTIVITY LIABILITY ACT, 1994 P.A. 351. BY SIGNING THIS RELEASE, I AGREE NOT TO BRING ANY CLAIM OR SUIT AGAINST CENTER OR PERSONS OR ENTITIES WORKING ON BEHALF OF OR AFFILIATED WITH CENTER ON THE BASIS OF ANY EXCEPTION IN THAT LAW.

4. *Indemnification*. I also agree to indemnify and hold harmless the CHEFF THERAPEUTIC RIDING CENTER, Cheff Therapy Services, and persons or entities working on behalf of or affiliated with the Center against all damages which are sustained or suffered by any third persons. The indemnification shall include reimbursement of Center's attorney fees.
5. *ASTM/SEI Headgear*. CHEFF THERAPEUTIC RIDING CENTER will provide me with an equestrian safety helmet that is ASTM-standard and SEI-certified for use when riding, handling, or being near horses. I understand that neither CHEFF THERAPEUTIC RIDING CENTER or its assistants or agents can guarantee the suitability of any helmet provided.
6. *Health and Disabilities*. I understand that Center always recommends that I seek the advice of a physician, and many of The Activities pose special physical risks to the participant and even to the volunteer. I want Center to be aware of the following physical conditions I have that may affect my ability to handle, ride, and/or be near an equine: _____
7. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by Center and/or persons directly affiliated with Center. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction located in or nearest to Kalamazoo County, Michigan.

8. ***Photo Release*** **– PLEASE CHECK ONE: I DO-☐** *or* **I DO NOT-☐ Consent to** and authorize the use and reproduction by CHEFF THERAPEUTIC RIDING CENTER of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibits, social media, or for any other use for benefit of the program.

SIGNATURE OF CONTRACTING PARTY _____ DATE _____

SIGNATURE OF OTHER CONTRACTING PARTY _____ DATE _____

CHEFF THERAPEUTIC RIDING CENTER
CHEFF THERAPY SERVICES

MEDICAL RECORDS RELEASE

Date: _____

_____ gives permission to
Client or Parent/Guardian

Cheff Therapeutic Riding Center to discuss case, or seek medical records from:

_____,
Health Care Provider

To better understand how best to serve the client.

_____
Client's name

_____
Parent/Guardian Signature

NOTICE OF PRIVACY PRACTICES

I have been provided with and/or read a copy of the Notice of Privacy Practices for Cheff Therapeutic Riding Center / Cheff Therapy Services.

_____ _____
Signature **Date**

CHEFF THERAPEUTIC RIDING CENTER
CHEFF THERAPY SERVICES

RELEASE OF CLIENT INFORMATION

for Caseworkers, Social Services, Insurance Co's, Attorneys, etc

Date: _____

_____ gives permission to
Client or Parent/Guardian

_____

to obtain client information such as contact information, progress notes, or equestrian skill goals from Cheff Therapeutic Riding Center.

_____
Client's name

_____
Parent/Guardian Signature

PERMISSION TO DISCLOSE CLIENT INFORMATION

for Additional Relatives or Friends

In accordance with the HIPAA law, Cheff Therapeutic Riding Center is asking for the names and contact information of **additional relatives or friends** who may be involved in your/your child's care or in the payment for your/your child's care while at Cheff.

By giving us this information, you are granting us **permission** to discuss **progress notes**, any **billing matters**, or other issues of concern which may arise while at Cheff with these individuals.

Date: _____

_____
Client's name

_____
Your name (printed) Signature

Other relatives or friends who are involved in the rider's care:

_____

Name & Relationship Ph # Email

_____

Name & Relationship Ph # Email