

Rocky Top Right TRAIL™ Program

A New Brand of Counseling

At Rocky Top Therapy Center, the Right TRAIL program uses an innovative form of therapy that incorporates horses into group, family, couples and individual counseling sessions.

Why a horse? Horses increase awareness of our own thoughts, feelings, words, and actions. They help us address and alter maladaptive coping strategies and behaviors in a new and challenging environment, which positively affects functioning outside of the therapeutic setting.

Trust

By building a relationship with a horse, individuals learn to trust and be trustworthy.

Respect

Respect for self and others is the foundation upon which all healthy relationships are built.

Assertiveness

Getting one's needs met through effective interpersonal communication skills.

Intrapersonal and Interpersonal Change

- Addressing anxiety, anger, depression, fearfulness, hopelessness, and self-harm through the reaction of the horse.
- Developing empathy, communication and interaction with others, and accepting responsibility for personal choices.
- Decreasing aggressive behavior, arguing, and defiance

Lifeskills

Teamwork, social skills, problem-solving, following intuition, and self-control are developed through activities with horses.

Services We Offer:

Group Counseling: \$75/person/session *Special Pricing for School Groups

We offer groups to address grief and loss, divorce recovery, anger management, spiritual growth, parenting, social skills, character training, at-risk children and adolescents, and addictions.

Couples Counseling: \$150/session/couple

Sessions address and seek solutions for the unique needs and concerns of each couple.

Family Counseling: \$150/session

Through activities with horses, families are able to address and alter unhealthy family dynamics.

Individual Counseling: \$120/session

Sessions are tailored to the specific needs of each individual.

* Sliding Fee Scale available upon request with proof of income.

For more information please call Kim Mills, LPC at 817-379-5717.

Equine Assisted Psychotherapy

Rocky Top Therapy Center offers Equine Assisted Psychotherapy (EAP), an emerging therapeutic intervention used in a variety of mental health settings, particularly in the treatment of children, adolescents and veterans. It is a type of recreational and adventure-based therapy loosely related to animal-assisted therapy. It combines traditional therapeutic interventions with a more innovative component involving relationships and activities with horses. **Through EAP individuals can address and alter maladaptive coping strategies and behaviors in a new and challenging environment, which positively affects their psychosocial functioning outside of the therapeutic setting.**

EAP is guided by treatment plans and diagnoses, and is facilitated by a licensed mental health professional and a qualified equine professional. The horse professional is primarily responsible for safety and for observing the behavior of the horse, because **the horse's reaction to the client is as powerful as the client's response to the horse.** The mental health professional is primarily responsible for the therapeutic aspects of the session.

While horse knowledge may be gained during EAP, it is not the main goal. **EAP is not horsemanship, it is "lifemanship."** The focus is on the *process* of participating in an activity with horses, and the client's behavior and response is central. The experiential aspect of EAP allows client's behaviors and emotions to surface in a way that traditional talk therapy does not allow. **Interventions involving activities with horses can help children, individuals, and families traverse chaotic life circumstances and give them a paradigm for success and positive peer interactions.**

Minor Client Information

Diagnosis Code _____

Client's Name _____ SS# _____

Parent/Guardian Name(s) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Gender _____ Date of Birth _____ Age _____ Grade _____

School

Current School _____ Phone _____

Previous School _____ Phone _____

Health

Who is your child's pediatrician? _____ Last visit? _____

Address _____ City _____ State _____ Zip _____

Any concerns shared by the doctor? _____

List all medications your child takes or has taken in the last year _____

Contact in case of emergency _____ Phone _____

List all prior counselors, dates seen and reason for counseling _____

Why are you seeking counseling? _____

How would you rate the intensity of the problem or concern that brought you in? (Circle number):

1 2 3 4 5
Not Intense Moderately Intense Extremely Intense

Approximately how long have you had the current problem? _____

How were you referred? _____

Family Status

List all family members living within the household from oldest to youngest (including client):

| Name | Age | Relationship |
|------|-----|--------------|
| | | |
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |

Parents living? Father Yes No Mother Yes No

Single Married Divorced Remarried Widowed

Describe your child's peer relationships _____

Describe your child's performance and behavior in school _____

Describe your child's relationships with family members _____

Are there any pets in the household? If so, what type? _____

How does your child typically deal with anger and frustration? _____

Adult Client Information

Diagnosis Code _____

Client's Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Gender _____ DOB _____ Age _____ Education Completed _____

Occupation

Employer _____ Phone _____

Address _____ City _____ State _____ Zip _____

Health

Who is your doctor? _____ Last visit? _____

Address _____ City _____ State _____ Zip _____

Any concerns shared by the doctor? _____

List all medications your child takes or has taken in the last year _____

Contact in case of emergency _____ Phone _____

List all prior counselors, dates seen and reason for counseling _____

Why are you seeking counseling? _____

How would you rate the intensity of the problem or concern that brought you in? (Circle number):

| | | | | |
|-------------|---|--------------------|---|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| Not Intense | | Moderately Intense | | Extremely Intense |

Approximately how long have you had the current problem? _____

How were you referred? _____

Family Status

List all family members living within the household from oldest to youngest (including client):

| Name | Age | Relationship |
|------|-----|--------------|
| | | |
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Marital Status

Single Engaged Married Divorced Remarried Widowed

If engaged, wedding date? ____ / ____ / ____

If married, when? ____ / ____ / ____

If divorced, when? ____ / ____ / ____

If widowed, when? ____ / ____ / ____

ROCKY TOP THERAPY CENTER

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 the agency, I authorize Rocky Top Therapy/T.R.A.I.L. Foundation to:

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

Physician's Name: _____

Preferred Medical Facility: _____

Insurance: _____

Designated Person: _____ Phone: _____

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 below is unable to be reached.

Date: _____ Consent Signature: _____
Client (parent or guardian if minor client)

Print Name: _____ Phone: _____

Address: _____

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 if minor client)

Print Name: _____ Phone: _____

Address: _____

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

Rocky Top Therapy Center
660 Keller Smithfield Rd.
Keller, TX 76248
817 379-5717

Participant Informed Consent & Voluntary Release Form

DISCLOSURE

At the Rocky Top Therapy Center, safety is our number one priority in the facilitation and management of all levels of programming, however, even with the adherence to recognized risk management practices in adventure programming and horse-related activities, accidents do occur. The level of participation in our programs is entirely voluntary and under individual choice at all times and for ALL aspects of the program or training.

Rocky Top Therapy Center programs and training involve a variety of activities including warm ups, discussion/debriefing, games, group initiatives (physical and cognitive), low challenge course elements (6-50 inches), horse-related activities, and other potentially rigorous physical/emotional activities. The inherent risks and other risks of this program are not unlike other physically and emotionally demanding activities and may include falls, heat stroke, hypothermia, anxiety and other fear responses, elevated heart rates, collisions with objects or other people, unsafe acts by other participants, acts of nature related to being in outdoor venues, and other risks that may be noted by participants and staff.

VOLUNTARY RELEASE OF LIABILITY

I am over 18 years of age. I assume full responsibility for myself and/or my minor children for all risks, inherent and otherwise, related to attendance and participation in this program sponsored by Rocky Top Therapy Center. By signing this release form, I agree to release and hold harmless Rocky Top Therapy Center and Newton's Rocky Top Ranch, Inc., their agents, assistants, employees, facilitators, all individuals assisting in instructing and conducting these activities, and co-sponsors including but not limited to their employees or agents, all shareholders, officers, directors of the corporation (collectively known as Releasees), for any damage or injuries, physical or mental, which I and/or my minor children might incur as a result of my voluntary decision to participate in "Right TRAIL™". By signing this release form, I agree that if I do sustain any physical injury or mental damage of any nature as a result of my voluntary decision to participate in the program ("Right TRAIL™"). On behalf of myself, my children, my heirs, personal representatives and next of kin, I hereby release and discharge Releasees and their successors, assigns, affiliates, directors, officers, employees and agents from any and all liabilities, claims, lawsuits, losses, costs, causes of action and damages of any kind originating or in any way arising from my or my children's participation in activities (Even if such claim is due in whole or in part to the negligence of releasees and their successors, assigns, affiliates, directors, officers, employees and agents.) The foregoing release includes a release of releasees and their successors, assigns, affiliates, directors, officers, employees and agents for their own negligence. In the event that any of my children, guests, or other third person shall assert any claims of whatsoever kind against the Releasees, their successors, assigns, affiliates, directors, officers, employees and agents, arising out of or related in whole or in part to any negligent act or omission by me in connection with program activities, I agree to indemnify and hold harmless the Releasees, their successors, assigns, affiliates, directors, officers, employees and agents from such claims and any related liabilities, obligations and expenses, including attorneys fees and other costs of investigation and litigation.

I assume full responsibility for myself and/or my minor children and guests for bodily injury, death, loss of personal property, and expenses thereof, as a result of my negligence, or other risks, including but not limited to those related to participation in any aspect of this program for the full duration of my participation in this program.

I acknowledge that I have been given the opportunity to ask questions regarding any aspect of this release form and by signing in the space provided do acknowledge that I have read completely and fully understand all aspects of this release form and agree to its terms in their entirety. I have been informed of the full nature of this program and its inherent risk and fully understand the nature of the program "Right TRAIL™" sponsored by Rocky Top Therapy Center.

MEDICAL INFORMATION

If I and/or my minor children do voluntarily choose to participate in the "Right TRAIL™" or other workshop sponsored by Rocky Top Therapy Center, I recognize that there is a significant element of risk in any adventure, sport or activity associated with outdoors, which may involve horse-related activities. Knowing the inherent risk, dangers and rigors involved in the activities, I certify that I and/or my minor children are fully capable of participating in the activities.

I disclose the following medical information so that Rocky Top facilitators and staff are properly informed. (Please indicate N/A if not applicable)

I am currently under a doctor's care for: _____

I am currently taking the following medication(s) (Please list any side effects which might affect your participation):

I am allergic to the following medications(s) or allergen(s), such as food, insect bites, poison ivy, etc. (Please bring medications for asthma or allergies with dosage marked with you, i.e. inhaler, epinephrine):

The following condition(s) might affect my participation: _____

By signing this release form, I assume full responsibility for all risks, inherent and other, related to my attendance and participation in this program sponsored by Rocky Top Therapy Center as noted in the Voluntary Release of Liability above. I further consent to first aid, emergency care and, if necessary, admission to an accredited hospital for treatment of injuries that I may sustain while participating in any activity associated with Rocky Top Therapy Ranch.

PLEASE SIGN

Participant Signature _____ Date _____

Participant Name (print) _____

Address _____ City _____ Zip _____

Parent/Guardian (if participant is under 18 years of age)

PARENT OR GUARDIAN AUTHORIZATION

In the event I cannot be reached in an **EMERGENCY**, I hereby give my consent to hospitalize and or secure treatment for my minor child.

Parent/Guardian Signature _____ Phone _____

Physician Name _____ Phone _____

Additionally, I grant to Rocky Top Therapy Center and persons acting for or through them, the rights to use, reproduce, assign and/or distribute photographs, films, videotapes, and sound recordings of myself for use in marketing or education materials they may create. I agree ___ decline ___ to release photo/media to Rocky Top Therapy Center (please check one)

Professional Disclosure Statement and Informed Consent

Please Initial Each Item:

- _____ The psychotherapy and/or counseling will be conducted by a qualified psychotherapist/counselor.
- _____ I understand according to the professional licensing law and professional ethics, these professional counselors are qualified to help me be released to experience further interpersonal and intrapersonal development.
- _____ Specific objectives and methods are to be agreed upon in consultation with the therapist. I understand that a non-physician therapist will not prescribe medicine.
- _____ The therapist is a consultant and resource professional. His/Her suggestions may be freely accepted or rejected by the client. Therefore, decisions made during and after therapy are the responsibility of the client.
- _____ Consultations, test results and disclosures between the counselor and the client will be held in confidence within the restrictions of Texas State Law. These exceptions to confidentiality include cases in which: (1) illegal activity is occurring (such as physical or sexual abuse); (2) the purpose of counseling is to obtain a court evaluation; or (3) legal action regarding the therapy itself (such as a malpractice suit) is in progress. The counselors are ethically and legally responsible to protect and maintain the counseling relationship while not in conflict with the basic laws of society.
- _____ I affirm that I have read all the conditions above and that they have been fully explained to my satisfaction. I understand and agree to them freely and without reservation.
- _____ I understand that Rocky Top Therapy Center does not provide 24- hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.
- _____ I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with the counseling services provided me, I have the right to inform my counselor. If I do not feel that my complaint is resolved, I may file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.
- _____ I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and my counselor will not initiate conversation.
- _____ Should I believe that a referral is needed, Rocky Top Therapy Center will provide some alternatives including programs and/or people who may be able to assist me.
- _____ I understand that all fees for counseling are due after each session.
- _____ I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, ARD meetings, classroom observations, legal depositions, interactions with insurance providers, phone calls over 5 minutes, etc. will be billed at \$120.00 per hour in 10-minute increments.
- _____ I understand that if a check is returned, a processing fee of \$25.00 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and \$25.00 processing fee. After a returned check, the Rocky Top Therapy Center and persons acting for or through them, may require cash payment of future appointments.
- _____ I understand that if a returned check is not cleared up in 30 days, Rocky Top Therapy Center and persons acting for or through them, will file a suit with the Denton County District Attorney's Office.
- _____ I understand that I am responsible for any appointments that are not canceled at least 24 hours prior to my appointment time, with the exception of an emergency. I understand that if I do not cancel my appointment 24 hours ahead of time, the fee for calling to cancel on the day of my appointment is \$120.00.
- _____ I understand that if I do not show up for an appointment will result in my being charged \$120.00 for the full missed session.
- _____ I understand that conducting expert witness/testimonial services is not an area of interest of Rocky Top Therapy Center and persons acting for or through them, as a factual case witness or involve them in court-related processes, she charges a retainer fee of \$1,500.00, with an additional \$120.00 every hour she is involved in legal dispositions, in case preparations, travel, and witness time.

_____ I understand that if I do issue Rocky Top Therapy Center and persons acting for or through them, a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.

_____ I understand that my records and all of our communications become part of the clinical record. Records are the property of Rocky Top Therapy Center and persons acting for or through them. Adult client records are disposed of seven (7) years after the client has stopped receiving services.

_____ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- I am a danger to myself or someone else.
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- Rocky Top Therapy Center and persons acting for or through them are ordered by a court to disclose information.
- You direct Rocky Top Therapy Center and persons acting for or through them in writing to release your records.
- Rocky Top Therapy Center and persons acting for or through them is otherwise required by law to disclose information.

Statement of Understanding

I have read the above and understand the nature of services providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge.

Client Signature (parent or guardian if minor client)

Date

Health Provider's Statement

I have inquired to insure that the patient understood the above description of the limits of confidentiality.

Health Provider's Signature

Date

HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students who see clients at our facility. In addition, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a treat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this agency:

Client Signature (parent or guardian if minor client)

Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Rocky Top Therapy Center to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payers, or any organization contracting with any of the above entities to perform such functions.

Client Signature (parent or guardian if minor client)

Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Rocky Top Therapy Center Right TRAIL™

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION

1. _____
Name of Client

_____ Birth date

_____ Street Address

_____ City, State, Zip

_____ Name of Authorizing Agent (Parent, Legal Guardian, etc.)

2. AUTHORIZES:

Right TRAIL™
Rocky Top Therapy Center
660 Keller Smithfield Road
Keller, TX 76248
(817) 379-5717

3. RELEASE PROTECTED MENTAL HEALTH INFORMATION TO AND FROM:

_____ Name of Health Care Provider/Plan/Other

_____ Street Address

_____ City, State, Zip

4. MENTAL HEALTH INFORMATION TO BE RELEASED:

_____ Clinical Record (Includes Treatment Summary, Background Information, Attendance and Fee Record and Consent Form)

_____ Psychotherapy Notes (According to HIPAA law, this request may be rightfully denied by the clinic)

_____ Verbal Communication/Consultation between mental health professional regarding your private health information

In compliance with Texas Statutes, which require special permission to release otherwise privileged information please release records pertaining to:

_____ Developmental Disabilities

_____ Alcoholism

_____ HIV (AIDS)

_____ Other (Specify): _____

_____ Drug Abuse

_____ Sexually Transmitted Diseases

FOR THE FOLLOWING DATE(S): _____

Rocky Top Therapy Center

Right TRAIL™

5. PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

- Further Medical Care Personal
 Insurance Eligibility/Benefits Changing Mental Health Professional
 Legal Investigation or Action Other (Specify): _____

6. I understand that is the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

7. Your Rights with Respect to This Authorization

- **Right to Inspect or Copy the Health Information to Be Used or Disclosed** - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my mental health information by contacting Kim Mills, (817) 379-5717.
- **Right to Receive Copy of This Authorization** - I understand that by agreeing to sign this authorization, I must be provided with a signed copy of the form.
- **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Kim Mills, (817) 379-5717. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

8. Disclosure of Direct or Indirect Payment Received by Any Person or Organization Authorized to Use or Disclose my Mental Health Information - I understand that the following person(s) and/or organization(s): Rocky Top Therapy Center, Right TRAIL™, will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information.

9. Expiration Date: This authorization is good until the following date(s) _____
or Event(s) (specify event) _____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

10. Signature of Client: _____ **Date:** _____
(If signed by person other than client, state relationship and authority to do so.)

Client is: Minor Incompetent Disabled Deceased

Legal Authority (Optional): Custodial Parent Legal Guardian Executor of Estate of Deceased
 Power of Attorney for Healthcare Authorized Legal Representative

ROCKY TOP THERAPY CENTER

660 KELLER SMITHFIELD ROAD
KELLER, TEXAS 76248
TEL # 817-379-5717 / FAX # 817-431-6100

PHYSICIAN RELEASE FORM

DATE: _____

RIDERS NAME: _____ D.O.B: _____

GENDER: _____ HEIGHT: _____ WEIGHT: _____ TETANUS SHOT: YES DATE: _____
NO

NAME OF PARENT/GUARDIAN _____

CONSENT FOR RELEASE OF INFORMATION: I hereby authorize _____ to
(physician or medical facility)
release the information from the records of _____. This information is to be
(rider's name)
released to Rocky Top Therapy Center for the purpose of developing a therapeutic riding program for
the above named client.

DATE: _____ SIGNATURE: _____

Dear Physician: Rocky Top Ranch and Therapy Center offer an equine assisted therapeutic program designed to benefit those with deficits in numerous areas. Safety equipment such as helmets and assistance belts are used and the horses are screened and trained for special needs riders. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following medical information before being considered for the program.

Diagnosis: _____ Date of onset: _____

Cause: _____

Medications (type, purpose, dose): _____

Mobility Status: Ambulatory yes no Independent Ambulation: yes no Crutches: yes no

Braces yes no Wheelchair yes no Sitting Balance Impaired yes no Standing Balance impaired
yes no

Please indicate any special precautions: _____

For persons with Down Syndrome:

Negative Cervical X-ray for Atlantoaxial Instability. X-ray date: _____

Negative for clinical symptoms of Atlantoaxial Instability

For persons with Seizure disorder:

Seizure Type: _____ Controlled: _____ Date of last seizure: _____

For persons with Scoliosis:

Degree: _____ Type: _____

RIDERS NAME: _____ D.O.B: _____

PRECAUTIONS AND CONTRAINDICATIONS INCLUDE:

| | | | |
|---------------------------|--------------------------------------|-------------------------|----------------------------------|
| ACUTE MS | BLOOD PRESSURE CONTROL | OSTEOPORISIS (SEVERE) | SPINAL FUSION |
| ACUTE HERNIATED DISC | COXA ARTHROSIS (degeneration of hip) | OSTEOGENESIS IMPERFECTA | SPINAL INSTABILITY |
| ACUTE STAGE OF ARTHRITIS | CRANIAL DEFICITS | PVD | SCOLIOSIS GREATER THAN 30' |
| ALLERGIES | DANGEROUS TO SELF/OTHERS | RESPIRATORY COMPROMISE | SPONDYLOLISTHESIS |
| ANIMAL ABUSE | HEMOPHILIA | SEIZURES UNCONTROLLED | SUBLUXATION DISLOCATION OF JOINT |
| ANTI COAGULANT MEDICATION | KYPHOSIS (EXCESSIVE) | SHUNT (S) | SUBSTANCE ABUSE |
| ATLANTO-AXIAL INSTABILITY | LORDOSIS (EXCESSIVE) | SKIN BREAKDOWN | SPINA BIFIDA UNSTABLE SPINE |

Please indicate if patient has a problem or history of problems and/or surgeries in any of the following areas by checking yes or no. If yes, please comment....

| AREAS | YES | NO | COMMENTS |
|--------------------------|-----|----|----------|
| AUDITORY | | | |
| VISUAL | | | |
| SPEECH | | | |
| CARDIAC | | | |
| CIRCULATORY | | | |
| PULMONARY | | | |
| NEUROLOGICAL | | | |
| MUSCULAR | | | |
| ORTHOPEDIC | | | |
| ALLERGIES | | | |
| LEARNING DISABILITY | | | |
| MENTAL IMPAIRMENT | | | |
| PSYCHOLOGICAL IMPAIRMENT | | | |
| OTHER | | | |

In my opinion, there is no reason why the person named as "rider" on this form cannot receive riding therapy under the appropriate supervision.

Precautions: _____

Physician's Signature _____ Date: _____

Physician's Name: _____ Tel #: _____

Address: _____ State: _____ Zip : _____

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE) AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.