



Rider Registration and Release Form

Date: _____
 (This form is to be updated annually)

| | | | |
|------------------------------------|------------|------------------------|------------------|
| Client | | D.O.B. | Age |
| Street | | City | State Zip |
| Phone # | Cell # | Disability | |
| Parent/Guardian | | Address (if different) | |
| Home Phone | Work Phone | Emergency | |
| Additional Emergency Contact/Phone | | | |
| E-Mail Address | | | |
| Responsible Party | | | |
| Primary Insurance Company | | | |
| Address | | City/State/Zip | Phone |
| Insured's Name | | Relationship to Client | Insured's D.O.B. |
| Insured's Social Security # | | Group Name or # | Effective Date |

PAYMENT TERMS :

Payment Type: Private _____ Insurance _____ Grant _____ Agency Referrals Name _____

I hereby acknowledge that Rocky Top Therapy Center is a non-participating provider with Medicare and all other insurance companies; therefore, I am responsible for the charges that are not covered by my insurance carrier.

_____ (responsible party / if under 18, parent or guardian must sign)
 Signature

LIABILITY RELEASE:

_____ would like to participate in the Rocky Top Therapy Center program. I acknowledge the risks and potential hazards of horseback riding; however, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed.

I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Rocky Top Therapy Center, it's Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees, the premise owner, Newton's Rocky Top Ranch, Inc., for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Rocky Top Therapy Center programs.

Date: _____ Signature: _____

PHOTO RELEASE: I hereby consent to and authorize the use and reproduction by Rocky Top Therapy Center of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date: _____ Signature: _____

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 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.

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: _____

Rider (if over 18), Parent or Guardian

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: _____

Rider (if over 18), Parent, or Guardian

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

PLEASE MAIL OR FAX COMPLETED FORM TO:
Rocky Top Therapy Center 660 Keller Smithfield Road, Keller, TX 76248
Phone: (817) 379-5717 or Fax: (817) 431-6100