RHYTHM OF THE REIN THERAPEUTIC HORSEMANSHIP

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802 426-3781 info@rhythmoftherein.org

EAAT ADMISSION FORM AND CONSENT TO PARTICIPATE AND CONSENT FOR MEDICAL TREATMENT

Client Name: _____ Date of Birth: _____Phone: _____
Address: _____ _____
Email: _____
Emergency Contact name: _____Emergency contact#: _____
Referring MD: _____ MD phone #:_____

Insurance _____ Group # _____
Address _____ Policy # _____
_____ Ins phone # _____
Other Insurance _____ Policy # _____
Address _____
Allergies: _____ Medications: _____

CONSENT TO TREATMENT: I/We, the client or parents/legal guardians, agree that Rhythm of the Rein, its employees, program volunteers, and others associated with Rhythm of the Rein may provide Equine Assisted Activities and Therapies (EAAT) as directed by my physician to me or my minor child/legal ward and have duly executed Rhythm of the Rein's Alternative Riding Program Agreement, Liability Release, and Assumption of Risk Agreement and hereby affirm my consent to release any and all of Rhythm of the Rein's owners, employees, agents and associates from liability from any risk, injury or harm that may occur as a result of the minor child's/legal ward's participation in EAAT. I further acknowledge that the possible benefits to myself or child/legal ward are greater than the risks assumed.

I/we authorize Dianne Lashoones, PT to bill my insurance for prescribed hippotherapy services if provided. I/we agree to pay any applicable co-pays and for any missed scheduled sessions that I/we do not give at least 24 hours prior notice of
cancellation. (There are no charges for sessions canceled by the provider.) ___ initialed

I/we understand the HIPAA privacy provisions that have been provided to me. ___ initialed

WARNING –Under Vermont law, an equine activity sponsor is not liable for any injury to, or the death of, a participant in equine activities resulting from inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. Section 1039.
For purposes of this agreement, I/we understand that the term "Equine Activity Sponsor" includes Rhythm of the Rein, and its instructors, therapists, volunteers, and/or employees. __ initialed

PHOTO RELEASE: I do ____\do not___ consent to and authorize the use of photos and video containing images of myself, child/legal ward for use on
social media, promotional information, and/or for educational activities, or for any other use for the benefit of Rhythm of the Rein.

____initialed

Signature of Legal Guardian(s): Date:

In the event emergency medical aide/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 Rhythm of the Rein 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 emergency medical treatment.

CONSENT PLAN:
This authorization includes x-ray, surgery, hospitalization, medications, and any treatment procedures deemed “lifesaving” by the physician. This provision will only be invoked if the person(s) above is unable to be reached.
I/we ___consent ___do not consent to emergency medical treatment. ___initialed

Consent/ non consent Signature: _____ Date: