Liability Release

In consideration of being allowed to participate in horseback riding with Walk on Water (referred to as WOW) I, for myself and any minor children for whom I am parent, legal guardian, or otherwise responsible and for my/our heirs, personal representatives or assigns, hereby acknowledge the risks of injury or damage (to property, personal injury and/or death) involved in horseback riding.

I understand that HIPPA regulations restrict the dissemination of Protected Health Information (PHI) between other members of the program, clients, or external parties. This agreement between our company “Walk on Water” and anyone associated with our business “Business Associate” will be listed in the Business Associate Agreement signed and agreed upon by both parties.

I understand that there is a risk in riding live animals and acknowledge that my/our participation in this activity is purely voluntary. I assume full responsibility for myself and any minor children for whom I am parent, guardian or otherwise responsible, for any bodily injury, accident, illness, paralysis, death, loss of personal property and expenses thereof because of any accident which may occur while I/we participate in the horseback ride and WOW. I/we further agree to abide by all safety instructions, and to wear any safety equipment provided or brought on the horseback ride while I/we are participating in the activity.

I, for myself and any minor children for whom I am parent, legal guardian or otherwise responsible, hereby release, acquit and forgive WOW principals, directors, officers, agents, and volunteers and its owner, Patricia Bryan from any and all liability of any nature for any and all injury or damage (including property damage, personal injury, illness, blindness, paralysis, and/or death) to me or said minor children as the result or my/our participation in horseback riding at WOW.

I, for myself and any minor children for whom I am parent, legal guardian or otherwise responsible, and for my/our heirs, personal representatives or assigns, also hereby expressly waive any claim, lawsuit, complaint, charge, or cause of action against WOW, its principals, directors, agents, employees and its owner, Patricia Bryan, and for any and all injury or damage, to me or any such minor children and other persons as a result of my/our participation in horseback riding at WOW.

I, for my/our heirs, personal representatives and assigns also hereby expressly agree to indemnify and hold Harmless WOW principals, directors, employees, and its owner, Patricia Bryan, including costs, expenses and counsel fees, from and against all claims, lawsuits, complaints, charges or causes of action arising from the participation in horseback riding at WOW and the activities for which this Release and Waiver Agreement is given.

Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walk on Water Equine Therapy Program

Intake Form

**Client Information**

**Insurance ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_

Gender: \_\_ Male \_\_ Female \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_

**General Health Information**  
Prescribing Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician's Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have any allergies? \_\_ Yes \_\_ No  
If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have any medical conditions we should be aware of? \_\_ Yes \_\_ No  
If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient take any medications? \_\_ Yes \_\_ No  
If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient participated in equine assisted therapy before? \_\_ Yes \_\_ No

**Emergency Contact Information**

Parent/Guardian Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information**  
What are your riders top three goals for the program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the clients goals for the therapy/treatment program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the family/caregivers expectations for the Client/Rider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have any behavioral concerns? \_\_ Yes \_\_ No  
If yes, please describe **(Impulse Control, Frustraters, and Motivators):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any physical limitations we should be aware of? \_\_ Yes \_\_ No  
If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent & Acknowledgment**  
I, the undersigned, acknowledge that all information provided is accurate and complete to the best of my knowledge. I consent to the participation of the above-named patient in the Walk on Water Equine Assisted Therapy Program.

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization of Emergency Medical Treatment

Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IEP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:

Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If emergency medical aid/treatment is requited due to illness or injury while at the facilities used by Walk on Water Equine Assisted Therapy, at an event sponsored by Walk on Water Equine Assisted Therapy, or at an event in which Walk on Water Equine Assisted Therapy is a participant.

**I authorize Walk on Water Equine Assisted Therapy to secure and retain medical treatment and transportation if needed. This authorization includes x-ray, surgery, hospitalization, medication, and treatment deemed “life-saving” by the physician if the person listed as Emergency Contact cannot be reached.**

CONSENT Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

(Signature of parent or Guardian if under 18)

Photo Release Form

I grant Walk on Water Equine Assisted Therapy the right to take photographs of me and/or my family when on Walk on Water Equine Assisted Therapy property or any Walk on Water Equine Assisted Therapy sponsored events. I authorize Walk on Water Equine Assisted Therapy, its assigns, and transferees to copyright, use, and publish these photographs or videos in print and/or other digital media. I agree that Walk on Water Equine Assisted Therapy. may use these photographs of me with or without my name for any lawful purpose, including, but not limited to such purposes as publicity, illustration, advertising, and web content.

**I understand and agree to the photo release form information.**

CONSENT Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

(Signature of parent or Guardian if under 18)

**Monthly Tuition Statement**

Your support is a blessing to our program and helps us to feed and care for our horses, pay for our property and improvements, and help individuals in our community who are risk have a place where they can be encouraged. Tuition is due by the **first lesson of the month** for the **entire month**. Payment options are through Venmo, Zelle, and Paypal.

**Note: Cash and Checks are acceptable if the previous options are unavailable, however, our program does not offer makeup lessons for out-of-pocket clients. Please make checks out to Walk on Water.**

**I have read and understood the above information regarding tuition and makeup lesson policies.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Addendum A)**

**HIPPA Protected Health Information Business Associate Agreement**

This Business Associate Agreement ("Agreement") is entered into as of [Effective Date], by and between Walk on Water Equine Assisted Therapy ("Covered Entity") and [Business Associate Name] ("Business Associate").

**1. Definitions**

* **Protected Health Information (PHI):** Any information, including demographic data, that relates to the individual's past, present, or future physical or mental health or condition, the provision of healthcare to the individual, or the past, present, or future payment for the provision of healthcare to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.
* **HIPAA Rules:** The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, including the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

**2. Purpose of Document:** The purpose of this business agreement is to outline Walk on Water’s policy on non-disclosure of the above defined “protected health information”. This information includes, but is not limited to, items discussed during sessions, paperwork pertaining to clients and family, or any notes taken about sessions or clients. Disclosure of such information is subject to the terms listed in the sections below.

a. **Use and Disclosure:** Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as required by law.

b. **Safeguards:** Business Associate shall use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement.

c. **Reporting:** Business Associate shall report to Covered Entity any use or disclosure of PHI not provided for by this Agreement of which it becomes aware, including breaches of unsecured PHI.

d. **Subcontractors:** Business Associate shall ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions and conditions that apply to the Business Associate with respect to such information.

e. **Access:** Business Associate shall make PHI available to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR §164.524.

f. **Amendment:** Business Associate shall make PHI available for amendment and incorporate any amendments to PHI as directed or agreed to by Covered Entity pursuant to 45 CFR §164.526.

g. **Accounting:** Business Associate shall document disclosures of PHI and provide an accounting of such disclosures as required under 45 CFR §164.528.

h. **Internal Practices:** Business Associate shall make its internal practices, books, and records available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

i. **Destruction or Return:** Upon termination of this Agreement, Business Associate shall return or destroy all PHI received from or created or received by Business Associate on behalf of, Covered Entity within the allotted time frame for protected records. Records may be retained for up to seven years from termination.

**3. Permitted Uses and Disclosures by Business Associate**

a. **Service Provision:** Business Associate may use or disclose PHI as necessary to perform the services set forth in any underlying agreements between the parties.

b. **Management and Administration:** Business Associate may use PHI for its proper management and administration or to carry out its legal responsibilities.

c. **Legal Requirements:** Business Associate may disclose PHI as required by law.

**4. Obligations of Covered Entity**

a. **Notice of Privacy Practices:** Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR §164.520.

b. **Restrictions:** Covered Entity shall notify Business Associate of any limitation(s) in the notice of privacy practices of Covered Entity under 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

c. **Revocations:** Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

d. **Restrictions on Use or Disclosure:** Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

**5. Term and Termination**

a. **Term:** This Agreement shall commence on the Effective Date and shall remain in effect until terminated by either party.

b. **Termination for Cause:** Upon either party's knowledge of a material breach by the other party, the non-breaching party shall provide an opportunity for the breaching party to cure the breach or end the violation. If the breaching party does not cure the breach or end the violation within the time specified, the non-breaching party may terminate this Agreement.

c. **Effect of Termination:** Upon termination of this Agreement, Business Associate shall return or destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity. If return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

**6. Miscellaneous**

a. **Regulatory References:** A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

b. **Amendment:** The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

c. **Survival:** The respective rights and obligations of Business Associate under Section 5(c) of this Agreement shall survive the termination of this Agreement.

d. **Interpretation:** Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

*IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Effective Date.*

**Business Associate Name** **(Client/Family, Volunteer, Staff, or Employee):**

**Name (Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature (Parent or Legal Guardian if Under 18):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Walk on Water Equine Assisted Therapy Use Only:**

**Name (Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_