



**Mailing Address**  
PO Box 6604  
Norco, CA 92860

**Campus Address**  
4211 Valley View St.  
Norco, CA 92860  
(951) 340-0431 phone  
(951) 893-5135 fax

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**Rider Application**

Please print legibly in blue or black ink.

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

Street: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_

Tel: Home: \_\_\_\_\_ Work/cell: \_\_\_\_\_

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

If rider is less than 18 years of age, the parent or legal guardian must complete the following:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Rider Profile**

Birthdate:    /    /                      Gender:                      Height                      Weight                      lbs

**Child's Health History**

Immunization Current?     Yes     No

Allergies?     Yes     No

If yes, please describe: \_\_\_\_\_

I am a returning rider: (circle one) YES NO

I have ridden with another riding program (circle one) YES NO

If yes, where and how long? \_\_\_\_\_



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Please fill in the short term goals you have for the rider as well as long term goals.

Short term goals that you would like to see fulfilled during our sessions.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Long term goals that you would like to see fulfilled during our sessions.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Other Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Preferred Days and Times of Lessons: \_\_\_\_\_  
\_\_\_\_\_

Do you prefer group or private lessons? \_\_\_\_\_

I have received a copy of and understand Leaps & Bounds Pediatric Therapy's No-Show/Cancelation Policies.

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Signature of Adult Rider or Parent/Guardian of Minor Rider

Date

**PLEASE RETURN THIS SIGNED FORM AT FIRST LESSON. THANK YOU!**

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**Riding No-Show and Cancellation Policy**

We are looking forward to having you with us. We ask that the following policies be adhered to so that we may be able to offer the best quality program possible.

1. Please arrive a few minutes early for your class. This will give you a chance to use the rest room, get your helmet on, and be ready to mount on time. It may not be possible to mount a late arrival if more than 20 minutes late and if the arena gate is closed and the class has already started, then you will not be able to ride that day.
2. We will consider you "absent" if you have notified us at least 24 hours in advance. Otherwise, we will consider you a "no-show".

**"No-Show, No-Calls" result in:**

**Decrease in recruiting and retaining volunteers**

**Unnecessary tacking and untacking of our horses**

**Inefficient use of staff and volunteers**

**Other children not able to participate in the limited spots**

3. If you will be absent, please call the office as soon as possible so that we may alert your volunteers. If you get a voicemail, please leave the message. Our volunteers drive the distance and fight traffic just like you do in order to help. By letting us know that you will be absent, we can let your volunteers know so they can plan their day. Please don't be a "no-show, no-call"!
4. In case of an emergency, the rider or parent/guardian should call within 24-48 hours after the emergency.
5. In case of a sudden illness, the rider or parent/guardian should call as soon as it is apparent they will not be able to attend due to illness.
6. Excessive absences (3 or more) or no-shows (more than 1), will be subject to losing your class slot and being placed at the end of the waiting list.
7. Riders who have been awarded a scholarship for the session and have more than 1 "no-show" will be subject to forfeiting the scholarship and being ineligible for future scholarships.
8. There will be no refunds for missed classes. Payment for the session is expected regardless of absences and no-shows.
9. If Leaps & Bounds Pediatric Therapy must cancel a class due to weather or other circumstances, we will schedule a make-up class toward the end of the session. Due to our schedule, it is not possible to schedule individual make-up classes for absences and no-shows.
10. If you must withdraw for the session after it has begun, please contact the office.

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Parent/Guardian Signature

Date



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**Release of Liability**

This release of liability made and entered into on \_\_\_\_\_, by and between Leaps & Bounds Pediatric Therapy, INC., and \_\_\_\_\_. In return for the use, today and on all future dates, of the horses, services, facilities and property of Leaps & Bounds Pediatric Therapy INC, the rider/patient, his or her parents/guardians, his or hers legal representatives hereby expressly agree the following terms and conditions:

- Rider/patient and parents/guardian has been advised that ASTM safety approved riding helmets with chin harness is required any time a person is mounted.
- Rider/patient and parents/guardian understands that hippotherapy services require a licensed physical therapist/physical therapist assistant and/or occupational therapist/occupational therapist assistant be present during the session.
- Rider/patient and parents/guardian agree to assume all responsibility and risks of injury, death, or property damage from the participation in equestrian activities. Further they agree to hold Leaps & Bounds, its officers, directors, employees, subcontractors, and volunteers free from liability or damages for any injury to person(s) or property damage or loss as a result of this participation.
- Rider/patient and parents/guardian and Leaps & Bounds acknowledge and agree that riding is a dangerous sport and horses are extremely unpredictable and dangerous by nature even if well train and handled properly.
- It is further agreed by all concerned and involved that every effort is always taken to protect horse and rider/patient from any danger that can be identified.

Rider Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_  
Parent/ Guardian Name (Print)

\_\_\_\_\_  
Parent/Guardian Signature

Date: \_\_\_\_\_



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## Patient Photo Release Agreement

**I decline** the use of my child's likeness, image, voice, and/or appearance in any way.

I, \_\_\_\_\_, give my permission to use my child's name, \_\_\_\_\_, likeness, image, voice, and/or appearance as such may be embodied in pictures, photos, video recordings, audiotapes, digital images, and the like, take or make on behalf of Leaps & Bounds Pediatric Therapy Inc. I agree that Leaps & Bounds Pediatric Therapy Inc. has complete ownership of such pictures, etc. including the entire copyright and may use them for any purpose consistent with the Leaps & Bounds Pediatric Therapy program mission. These uses include, but are not limited to: illustrations, bulletins, exhibitions, video tapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials and any other mediums including the internet. I acknowledge that I will not receive any compensation, etc. for the use of these pictures etc. and hereby release Leaps & Bounds Pediatric Therapy Inc. and any of its agents and assigns from any and all claims which arise or are in any way connected with such use.

I have read and understood this consent and release.

I give my consent to Leaps & Bounds Pediatric Therapy Inc. to use my name and likeness to promote the program, its fiscal agent, and/or their activities.

Parent/Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Printed Name of rider: \_\_\_\_\_

Date: \_\_\_\_\_



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## HIPAA Confidentiality Agreement

### Policy:

Leaps and Bounds Pediatric Therapy will take appropriate disciplinary action against any member of its workforce who violates its privacy policies and procedures or an applicable city, state, or federal confidentiality law or regulation, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### Procedures:

1. Violation of privacy policies or procedures. Failure to comply with privacy policies or procedures will result in disciplinary action against the individual committing the violation.
  - a. Privacy policies and procedures will be enforced consistently across the organization.
  - b. Sanctions that are imposed as a result of a violation of privacy policy or procedures will be imposed consistently across the organization.
  - c. The following types of conduct on the part will result in disciplinary action against the individual engaging in the conduct:
    - i. Accessing a VIP's medical record for any purpose outside of treatment, payment, or health care operations.
    - ii. Discussing a patient's PHI in a public area.
    - iii. Failing to logoff or leaving a computer monitor on and unsecured.
    - iv. Accessing a patient's PHI out of curiosity or for any purpose outside of treatment, payment, or health care operations.
    - v. Using a patient's PHI for personal reasons (such as developing a personal relationship with the patient) rather than for legitimate and authorized business reasons.
    - vi. Copying or compiling PHI with the intent to sell or uses the PHI for personal or financial gain.
2. Disciplinary action that may be taken.
  - a. Will be determined on a case by case basis, taking into consideration the specific circumstances and severity of the violation; and
  - b. May be up to and including termination of employment, or of the business relationship as appropriate.
  - c. Sanctions that may be imposed include, but are not limited to:
    - i. A letter to the employee's personnel file;
    - ii. Administrative leave without pay;
    - iii. Attendance and successful completion of additional training;
    - iv. Reimbursement of expenses incurred by Columbia University Medical Center to resolve the matter; or
    - v. Immediate termination of employment.
3. Violations of state or federal confidentiality laws and regulations. Disciplinary action will also be taken against individuals or entities who violate related state or federal confidentiality laws and regulations.
4. Duty to report. Any workforce member who observes or becomes aware of or suspects a wrongful use or disclosure of PHI is required to report his/her suspicion or the wrongful use or disclose as soon as possible to his/her supervisor or the HIPAA Privacy Officer. A workforce member who makes a report of a suspected or actual improper use or disclosure in good faith will not be retaliated against for making the report. A workforce member who fails to report either a suspected or actual violation will have violated this policy, and may be subject to disciplinary action up to and including termination.
5. Definition
  - a. Protected Health Information (PHI) means information, including demographic information that may identify the patient, that relates to the past present or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual and identifies or reasonably be used to identify the individual. Workforce means employees of, volunteers and trainees regardless of whether they are paid.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date