VICTORY
THERAPY CENTER

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
—MEMBER—

Dear Prospective Participant:

Thank you for your interest in receiving equine-assisted services at Victory Therapy Center (Victory), a PATH International Member Accredited Center located in Roanoke, Texas, providing both Physical Therapy incorporating Hippotherapy and Therapeutic Horsemanship. We are a 501c(3) non-profit organization utilizing 17+ horses, 150 trained volunteers, and a highly qualified staff to help make miracles happen!

In order to provide the safest and best therapeutic environment to all our participants, Victory has established policies and procedures for acceptance into the program. It is a Victory requirement that participants be at least two years of age and have emerging head and neck control for Physical Therapy incorporating Hippotherapy. Participants must be at least four years of age to participate in Therapeutic Riding with a PATH Intl. Certified Therapeutic Riding Instructor.

An initial evaluation will be conducted by the Physical Therapist or the Program Director to determine the most appropriate path of therapy for each individual. In compliance with PATH Int'l Standards, participants will be periodically reassessed.

Participant guidelines have been established to ensure safety. If the individual meets initial criteria for equine assisted services, then thoroughly complete the enclosed forms. The Physician's Release form must be completed and signed by your physician ***prior*** to participation. Many forms require a signature and date. All forms must be returned before you or your family member can be enrolled.

Upon completion of the evaluation, required paperwork and acceptance into the program; the participant will be assigned an appropriate class time or be placed on a waiting list until an appropriate class time is available. Victory sessions are scheduled based on participant needs, age, and goals, as well as availability of staff, volunteers, and an appropriate horse. To increase your chances of securing a place in the class schedule, be sure to note ALL times that you are available to participate. If placement on a waiting list is necessary, you will be contacted when a time becomes available.

In this packet, you will find other useful information about the Victory program such as our goals and fees. If you have email access, please note it on the application form. A great deal of information is disseminated to our participants electronically. Please call Victory's office at 682-831-1323 if you have any questions concerning this process. We look forward to working with you!

Forms may be faxed, emailed, or mailed to:

Victory Therapy Center
New Participant Registration
10600 Dunham Rd
Roanoke, TX 76262
Fax: 682-831-1362
programs@victorytherapy.org

Victory Therapy Center ~ With you every step of the way!

Victory Therapy Center offers services that improve a participant's quality of life through the healing spirit of the horse. Victory uses a team approach to provide treatment with the guidance of PATH Int'l Certified Therapeutic Riding Instructors and Licensed Physical Therapists. The horse provides a unique opportunity to achieve goals that enhance physical, emotional, social, cognitive, behavioral, and educational skills for people who have disabilities by not only focusing on horsemanship skills, but also the development of a relationship between horse and participant.

Victory has provided equine-assisted services to children and adults with physical, cognitive, and emotional disabilities in North Texas for over 30 years. Victory currently serves over 100 participants weekly ranging from age 2 to 86. Program services provide the opportunity for improved quality of life for individuals of all life stages.

Our vision is to be innovative in the field of equine-assisted services and to explore new and dynamic approaches to equine-assisted services. We compassionately partner with and recognize the role that the horse plays as an integral part of our team. At Victory, it is our priority to maximize the benefits to the participant while fostering this partnership between horse and participant.

Some of the needs or disabilities serviced at Victory Therapy Center include (but are not limited to):

- Amputation
- Attention Deficit Hyperactivity Disorder
- Autism
- Brain Injury
- Cancer
- Cerebral Palsy
- Down Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Post-Traumatic Stress Disorder
- Sensory Integration Dysfunction
- Spina Bifida
- Spinal Cord Injury
- Stroke
- Visual/ Hearing/ Speech Impairments

Unfortunately, there are some precautions and contraindications that may preclude us from providing services to a participant. The following list will be reviewed during the initial assessment. If any of the conditions exist, equine assisted services are not generally recommended; and the Program Director will have further discussions with you regarding Victory's ability to provide safe therapy.

- Acute MS
- Acute Herniated Disc
- Acute Stage of Arthritis
- Allergies
- Animal Abuse
- Anti Coagulant Medication
- Atlanto-Axial Instability
- Blood Pressure Control
- Coxa Arthritis (degeneration of hip)
- Cranial Deficits
- Dangerous to self/ others
- Hemophilia
- Kyphosis (excessive)
- Lordosis (excessive)
- Osteoporosis (severe)
- Osteogenesis Imperfecta
- PVD
- Respiratory Compromise
- Seizures Uncontrolled
- Shunt (s)
- Skin Breakdown
- Spinal Fusion
- Spinal Instability
- Scoliosis greater than 30'
- Spondylolisthesis
- Subluxation Dislocation of Joint
- Substance Abuse
- Spina Bifida- unstable spine

Victory Therapy Center Participant Registration Form

(This form is to be updated annually)

Please print clearly. Date: _____

Client		D.O.B.	Age
Street		City State/Zip	County
Home Phone	Cell	Diagnosis	
Parent 1/Guardian		Address (if different)	
Home Phone	Cell Phone	Work Phone	
Preferred Contact Method (circle one)	Home phone	Cell Call / Text	Email
Email Address			
Parent 2/Guardian		Address (if different)	
Home Phone	Cell Phone	Work Phone	
E-Mail Address			
Additional Emergency Contact Name and Phone			
Responsible Party			
Preferred Invoice Delivery Method (circle one and identify correct address/email address) Mail Email			US

NOTICE REGARDING INSURANCE:

I hereby acknowledge that Victory Therapy Center is a non-participating provider with Medicare and all other insurance companies and **does not** direct bill; therefore, I am responsible for billing my insurance. I am also responsible for any charges that are not covered by my insurance carrier.

Signature (if under 18, parent/ guardian must sign): _____

LIABILITY RELEASE:

_____ would like to participate in the Victory 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 Victory Therapy Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees, for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Victory Therapy Center programs.

Signature: _____ Date: _____

Authorization for Emergency Med Treatment _____ Date: _____ Decline: _____

Victory Policies & Procedures

Equine Assisted Service Sessions: Based on the needs and abilities of a participant, an individualized program will consist of Physical Therapy incorporating Hippotherapy or Therapeutic Horsemanship. Therapeutic Horsemanship classes with 1-3 participants are 45 minutes in length. Classes with 4-5 participants are 60 minutes in length to allow extra time for mounting and dismounting. Class time **includes time to mount, 30 minutes of mounted instruction, dismount time and other activities at the instructor's discretion; for example, putting away tack, grooming and giving thank-you treats to horses**. In some cases, session times may be shortened to accommodate a participant's special needs. Occasionally, unmounted horsemanship lessons are conducted in lieu of a mounted activity, such as when weather conditions would make a mounted activity unsafe. Please keep in mind unmounted activities are beneficial for teaching a variety of life skills.

Fees:

Physical Therapy Evaluation $180 (annual)
Physical Therapy $40 per 15-minute unit (Sessions are 30 minutes to 1 hour)
Physical Therapy Monthly Re-evaluation $5 (required every other month)
Therapeutic Horsemanship – Private $85/lesson payable by Session*
Therapeutic Horsemanship – Group (2-5) $60/lesson payable by Session*

Payment Policy:

1. Payment from individuals must be received each session prior to services being rendered. In addition to full payment, other payment options are available: monthly or 2 equal payments. This can be arranged by contacting our Finance Manager at accounting@victorytherapy.org.
2. **Full TR Session fee applies regardless of number of times present for scheduled class time. Clients will be responsible for payment of missed visits unless a doctor's note for that day is provided to your instructor.**
3. **Any rider that has an account 30 days past due will not be able to ride until their account is brought current. No Exceptions.**
4. **An option to provide a credit card on file for monthly payments has been added. Specific payment dates may be arranged directly with our Finance Manager.**
5. Agency-funded therapy will be billed directly to the Agency on a monthly basis, or as per requirements.

***Sessions:** Length of sessions varies by season. See current Session Calendar for specifics. Sessions do not apply to Physical Therapy participants.

NOTE: PT Participants do not participate in the session calendar. Specific closure dates will be communicated by your therapist.

Holidays: Refer to current Session Calendar for holiday closures. If a participant has a lesson scheduled on a holiday closure, he/she will not be charged for that lesson.

Progress Reports: Instructors will maintain regular progress reports on each participant. Goals and objectives will be reviewed and adjusted as necessary.

Annual Paperwork: Victory Therapy Center maintains ***required*** participant paperwork on an **annual** basis. This includes updated Participant Registration, HIPAA, PT Prescription (if doing Physical Therapy), and a Physician's Release. This ensures Victory has the most current information on file for all clients. New packets will be distributed at the end of each year with a return deadline. A participant's services may be put on hold if this paperwork is not complete.

Weight Guidelines: A participant's weight plus tack should not exceed 20% of the horse's weight. At this time, we cannot accommodate riders over 230lbs for mounted lessons. Please talk with your Instructor/Therapist if you have any questions.

Unmounted lessons will be offered if:

1. Participant becomes too large or heavy for the program to serve safely mounted on a horse or;
2. Program does not have suitable mount for participant

Safety Requirements: It would be a contraindication for participation in the program if any of the following situations occur:

1. A participant's physical condition is exacerbated by participating.
2. An appropriate horse is not available for the client.
3. The participant's behavior poses safety concerns for the participant, staff, volunteers, or horse (at the discretion of the instructor, and/or Program Director, and/or Equine Director).
4. Required paperwork has not been received.

Be aware of safety barriers, hazards, or other restricted areas in our Waiting Area. Participants must be supervised by Victory personnel beyond this point; this is to ensure the safety of both participant and horse.

Parents, guardians, or designated agents must remain on the premises during lessons.

Punctuality: It is important for a participant to arrive on time for his or her lesson. Consideration should be given that mounted time of a lesson will be no more than 30 minutes. The rest of the lesson time is used for mounting, dismounting, grooming, and giving 'thank you' treats to the horses.

Late Arrival Policy: If a participant is late for a scheduled therapy time, Victory cannot guarantee he/she will be able to participate. Once the lesson has begun, the instructor may not be able to leave other participants in order to mount late arriving participants. Therefore, horses will be untacked, and volunteers released 15 minutes after the scheduled start time of the class.

Attendance: For best results, regular and consistent therapy is recommended. Arriving late or missing appointments impairs a participant's ability to progress, disrupts staff schedules, limits other participant's ability to arrange appointments and may impact Agency coverage. It is important that Victory maximize appointment scheduling to control therapy costs. We understand that emergencies do arise and will handle these on a case-by-case basis.

Please note the following cancellation policy:

1. Please document your attendance by signing in on the Daily Participation Schedule on the podium next to your name. This is required for both safety reasons (in case there's an emergency) and for billing purposes.
2. If you are unable to make your lesson, please give Victory a minimum of 24-hours' notice. If you have a last-minute cancellation, call the office at 682-831-1323, or your instructor directly.
3. **Physical Therapy Cancellations made less than 24 hours prior to an appointment will result in a $25.00 cancellation fee billed on the following months invoice. We understand that emergencies happen, or a participant may get sick within the 24-hour cancellation period. If this happens, please contact your therapist as soon as possible to cancel the session. The reason for cancellation will then be reviewed. Agencies will not pay these charges, so families need to be prepared to pay out of pocket. If you do not**

call and do not come for your scheduled appointment time, you will be charged a $25.00 no show fee that will be billed on the following months statement. Victory utilizes many volunteers who arrange their time to assist with classes and makes every attempt to advise them when they are not needed for a class.

4. **If your fees (TR or PT) are paid by a service provider (DSSW, Scoggins, ARK, SIT, etc.) Victory can only bill for days that you receive services. Therefore, to keep things fair for all participants, if you have an unexcused absence or do not show up for the session, you will be charged a cancellation fee of $25.00 for which you will be responsible. If the session is canceled by Victory, no fee will be charged**.
5. **Three (3) cancellations in a session OR five (5) cancellations per calendar year could result in the loss of your scheduled appointment time and/or scholarship.**
6. **Victory's schedule leaves little to no room for scheduling make-up classes. Therefore, cancellation will have no guarantee that a make-up lesson can be scheduled.**

Weather Policy: Victory follows the NWISD cancellation policy, so if NWISD cancels classes in the event of a national weather advisory Victory will as well. Victory will cancel classes in the event of a national weather service warning for Denton or Tarrant Counties.

Victory uses the Weatherbug app with a Roanoke location to make any weather determinations. While we will make every effort to hold mounted lessons, the following are examples of when unmounted horsemanship lessons will be substituted for mounted lessons. If an unmounted horsemanship lesson is not appropriate for a participant, then the lesson would be cancelled all together.

1. If there is thunder and/or lightning within 10 miles of the facility. Victory instructors use the "Spark" feature on the WeatherBug app to determine lightning proximity.
2. If temperature + humidity is over 150.
3. If temperature, or "feels like" temperature, drops below 32 degrees Fahrenheit.

In the event of a lesson cancellation due to inclement weather, Victory will make every attempt to notify the participant or their representative. It is the responsibility of the participant to ensure that Victory has a current phone number and/or email address for participant notifications.

Clothing Requirements for Participants:

1. ASTEM/SEI approved helmet (can be provided by Victory)
2. Closed-Toe shoes or boots, preferably with heels
3. Long pants (slippery sport pants are not appropriate for riding
4. Gloves or jacket, as needed

Siblings: If siblings are in attendance with parents of students or clients participating in class, **parents are responsible for direct supervision at all times.** Noise and disruptive activity distract horses and participants and can be a safety issue especially during transfers at the ramp and when grooming and tacking.

Conduct While at Victory: It is important that everyone complies with all posted safety rules; therefore, obey all posted off-limit areas. Victory is **a "no smoking" facility** and the use of drugs, alcohol or firearms on the property is strictly forbidden. No mistreatment or abuse of any person or animal will be tolerated.

Discharge Policy:

Victory Therapy Center reserves the right to discharge any participant from the program at any time. Reasons for discharge may include, but are not limited to the following:

1. Incomplete required paperwork;
2. Participant's condition or behavior becomes a safety issue;
3. Participant progresses to a level of skill that they may be better served by a more traditional horsemanship program.

*** Victory is a "no smoking" facility. This includes cigarettes, cigars, pipes, and vaporizers.**

*** Due to insurance reasons (including safety concerns for horses), only "working" Service Dogs on leash with their service vest on who are quiet and obedient to their handler, are allowed on property in the Waiting Area. Do NOT approach any horses with the service dog inside or outside of fencing; horses (prey) are typically very afraid of dogs (predators).**

Acknowledgement of Receipt of Victory Policy & Procedures Document

Participant/Guardian,

Please complete below and return to your instructor prior to participation.

I, _____, have received a copy of, understand and agree to the attached Policies & Procedures for Victory Therapy Center regarding Participant _____.

_____ _____
Signature Date

PHOTO RELEASE (initial box and sign):

☐ I hereby consent to and authorize the use and reproduction by Victory 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.

☐ I hereby DO NOT consent to the use and reproduction by Victory 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.

Signature: _____ Date: _____

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

Notice of Privacy Practices

Our Legal Duty:
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the notice while it is in effect. This notice is an update for the effective regulations of April 24, 2003 and will remain in effect until we replace it.

Use and Disclosures of Health Information:
We use and disclose health information about you for treatment, payment and healthcare operations. This includes but not limited to the following:

- Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.
- Payment: We may use and disclose your health information to obtain payment for services we provide you.
- Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations.
- Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.
- Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up health information or other similar forms of health information.
- Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
- Required by Law: We may use or disclose your health information when we are required to do so by law.
- Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials your health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
- Reminders: We may use or disclose a portion of your health information to provide you with appointment reminders, school excuses, etc. such as voicemail messages, postcards, or letters.

Patient Rights:
- Access: You have the right to look at or obtain copies of your health information, with limited exceptions.
- Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)
- Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of the Victory Therapy Center Notice of Privacy Practices regarding _____.
(Patient Name)

Patient/Guardian Signature: _____ Date: _____

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: Victory Therapy Center 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 VTC Staff/Instructor: _____ 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.

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

Print Name: _____ Phone: _____

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 beingon the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:
_____
_____

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

Print Name: _____ Phone: _____

PHYSICIAN RELEASE FORM

CONSENT FOR RELEASE OF INFORMATION:

I hereby authorize _____to release the information from the records
(Physician or medical facility)
of _____. This information is to be released to Victory Therapy
(Rider's name)
Center for the purpose of developing a therapeutic riding program for the above-named client.

SIGNATURE: _____ DATE: _____

Dear Physician: Victory Therapy Center offers 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

RIDERS NAME: _____ D.O.B: _____

NAME OF PARENT/GUARDIAN _____

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

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: _____

PRECAUTIONS AND CONTRAINDICATIONS INCLUDE (circle all):

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			

Precautions:

_____
_____
_____
_____
_____

In my opinion, there is no reason why _____ cannot receive riding therapy under the appropriate supervision.

Physician's Signature: _____ Date: _____

Physician's Name: _____
(Please print)

Telephone: _____ Email: _____

Address: _____

Additional Comments:

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PHYSICAL THERAPY PRESCRIPTION

Patient Name: _____ Patient D.O.B: _____

Diagnosis (ICD-10 Code): _____

Goals of Rehabilitation to include:

_____ Improved Range of Motion
_____ Improved Gait
_____ Increased Strength
_____ Improved Midline Orientation
_____ Establish / Upgrade Home Exercise Program
_____ Improved Posture / Biomechanics
_____ Improved Functional Ability
_____ Improved Motor Planning
_____ Improved Balance

Frequency: _____1-2x/week_____ Duration: _____1 Year_____

Comments/Recommendations:_____
_____
_____
_____
_____

Physician Signature: _____ Date: _____

Physician Name: _____

Address: _____

Telephone #: _____ Fax #:_____

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