Queen of Hearts Therapeutic Riding Center, Inc.

6407 Dana Avenue, Jurupa Valley, California 91752 - (951-734-6300)

Welcome to Queen of Hearts Therapeutic Riding Center, Inc.

Thank you for your interest in equine-assisted activities at Queen of Hearts Therapeutic Riding Center, Inc. (hereinafter "Queen of Hearts").

Queen of Hearts is a 501(c)(3) equestrian center for persons with special needs. Our mission is to improve the bodies, minds, spirits, and quality of life of persons with physical and/or developmental disabilities and/or mental illnesses through equine-assisted services. Services can be ground-based, adaptive riding, or a combination of both. Queen of Hearts also partners with mental health professionals to offer equine-assisted psychotherapy.

Attached is our Participation Registration packet which must be completed and returned prior to participation in our program.

Operating Hours

Queen of Hearts is currently open Mondays through Thursdays from 9a.m. to 7p.m. and Fridays through Saturdays from 8a.m. to 1p.m. Additional hours may be added as deemed necessary.

Fees, Enrollment Process and Services Offered

All enrollment forms, medical releases, assessments, and other required documentation must be received by Queen of Hearts prior to participation in any equine-assisted services.

Queen of Hearts does its best to keep costs low. Tuition for each lesson/session (hereinafter referred to as "lesson") only covers 1/3 of the actual cost of providing services. Program fees are not tax-deductible and are billed monthly. (Note: Prices are subject to change.)

- Current pre-pay options are Cash, Check, Venmo, Square, or PayPal. Pre-payments are due prior to service.
- Third party payments are billed at the customary billed price.
- Full and partial scholarships are occasionally available. For more information, contact an office staff member.

Queen of Hearts does its best to fundraise to keep the programs accessible to all who need it. If you are interested in assisting with fundraising, please reach out to the Executive Director, Robin Kilcoyne.

Therapeutic Riding Instruction and Horsemanship (TRI/H)

Unmounted (working alongside of the horse or in an arena) and mounted (while on horseback) activities improve information processing, retention, confidence, self-awareness, self-esteem, daily living/coping skills and education objectives.

Intake: $70 – Intake Assessment (one-time fee)

There will be an initial evaluation/assessment of participants prior to the first session by a PATH Intl. Certified Therapeutic Riding Instructor. The instructor will review all enrollment forms and will work with participants and their caregivers to decide the type, length, and frequency of each lesson needed to meet established goals.

Typically, participants start with eight (8) 45-min private lessons to encourage positive interactions and establish trust between the participant, horse, and their Instruction Team. Lesson type, length, and frequency are typically re-evaluated at the end of 8 lessons.

TRI/H sessions can be either pre-paid or billed as follows:

- $100 pre-paid 45-minute individual private lesson x 4 lessons = $400
- $75 pre-paid 45-minute group lesson x 4 lessons = $300 per person
- $150 billed 45-minute individual private lesson x 4 lessons = $600 per person
- $100 billed 2-3-person group lesson x 4 lessons = $400 per person

Equine-Assisted Psychotherapy and Learning (EAP/L)

EAP/L are experiential forms of psychotherapy and learning that involve equines. As social, feeling beings, horses intuitively feel our emotional state and respond accordingly, offering immediate feedback. Queen of Hearts follows the EAGALA Model of equine assisted psychotherapy:

1. All sessions are conducted by a facilitation team of a licensed Mental Health Professional (MH) and a qualified Equine Specialist (ES), and the horses.
2. All sessions are on the ground – there is no riding of horses involved in the treatment process.
3. The process is solution-oriented – meaning we believe you have the best solutions for yourself when provided the opportunity to discover them.
4. This process also incorporates "Best Practice" or "Evidence Based" interventions as determined by the Mental Health profession

EAGALA sessions can be either pre-paid or billed as follows:

- $150 pre-paid 45-minute individual private session x 4 sessions = $600
- $200 pre-paid 45-minute group session x 4 sessions = $800
- $175 billed 45-minute individual private session x 4 sessions = $600 per person
- $250 billed 45-minute group session x 4 sessions = $1,000

Scheduled Lesson Times

Participant lesson times are scheduled for a pre-determined date and time which remains the same from week to week throughout the applicable session. **If a participant is more than 10 minutes late for a lesson without notification, the lesson will be forfeited.** If a participant needs to change his/her schedule, arrangements may be made if there is an opening available. **Queen of Hearts requires a 24-hour notice if a participant needs to cancel his/her lesson. Less than 24-hour notice cancellation or no-shows may be charged for the missed lesson.**

Missed Lessons

There are no refunds or credits for missed lessons/sessions. Lessons *may* be rescheduled ***if*** **time permits within the same week** or if there are unforeseen circumstances such as inclement weather. If a participant anticipates missing two (2) or more lessons within a 4-week period, Queen of Hearts may request that the participant give up his/her time slot and, *if* the time slot is still open when the participant returns, then the participant may be placed back on the same schedule.

Rain Days/Inclement Weather

For the safety of the participants, staff, and the humane treatment of the horses, it is Queen of Hearts' policy to not conduct lessons on horseback in the rain, high wind conditions, or when the temperature exceeds 95°F. If the lesson must be cancelled by Queen of Hearts, all attempts will be made to reschedule the participant at a mutually convenient time during the same week. If there are no available time periods within the same week, the lesson will be "rolled over" to the next lesson.

Refund Policy

Queen of Hearts has a no refund policy. In the event of extended absences, such as a prolonged illness/injury (such as an infectious virus or an injury that will be aggravated by horseback riding), a credit will be held for unused lessons. If a participant chooses not to return, the credit may roll over to another family member that is already enrolled in the program within sixty (60) days.

What Participants Should Wear

Helmets: ALL riders MUST wear an ASTM/SEI approved helmet. Queen of Hearts is happy to loan a helmet to participants, however, it is best if each participant obtains his/her own. Your instructor can help you with the proper fit.

Pants: All participants must wear long pants during lessons. If riding, jeans and other trousers should be loose enough to allow the rider to sit comfortably. There should not be a tight crease or pressure across the hips, upper thigh, and abdomen. Cotton sweatpants also work very well. Nylon pants, however, can cause the rider to not have a secure seat in the saddle.

Jacket/Sweater: Jackets and sweaters should not be too long. Riders should not be able to sit on the back of the jacket and sleeves should not extend past the riders' wrists. The jackets/sweaters should be zipped, buttoned, or snapped closed when riding; loose, flapping jackets can distract the horse and riders.

Footwear: Sneakers should be avoided. Riding boots with low heels are ideal for most riders. Please ask your instructor for local stores where new and used footwear can be obtained.

Leg Braces: Many riders can wear short leg braces when they ride because they help support the ankle. However, if the rider rides without stirrups, it may be more beneficial to remove the braces so the lower leg can easily contour to the horse. Please discuss the options with your instructor.

GENERAL RANCH RULES

- There is NO SMOKING allowed anywhere on ranch grounds.

- PLEASE DO NOT DISTURB LESSONS THAT ARE IN SESSION or attempt to talk to the instructors while they are teaching a class. For safety and effective teaching, the instructor's full attention is on the participants, and the participant's full attention must be on the instructor and their horses.

- **Non-confidential Sessions**: Parents, caretakers, friends, relatives, and siblings are welcome to stay and observe the classes in session. We ask that observers stay within the confines of the "Parent Park." We ask that you watch your children and PLEASE **DO NOT ALLOW** CHILDREN TO CLIMB ON THE MOUNTING RAMPS OR FENCES, VISIT THE BARN, OR STRAY INTO THE HORSE STAGING AREA.

- **Confidential Sessions: All EAGALA sessions are considered Confidential.** Parents, caretakers, friends, relatives, and siblings are not permitted to observe sessions. We request that all non-session individuals wait outside the privacy fence.

- PLEASE DO NOT CLIMB on the arena gates, railings, fencing or barriers.

- Do not leave children unattended. Do not allow children to run or play loudly at any tiem. No bikes, roller skates or skateboards are permitted.

- Please **do not take photographs or videos of participants** while class is in session without prior permission.

- Observers are welcome to bring snacks, drinks, and sack lunches to enjoy while watching their rider's lesson. Please dispose of refuse in the black trash cans. NO ALCOHOLIC BEVERAGES ARE ALLOWED.

- Visitors are not allowed in the barn/tack area, or beyond the arena without the accompaniment of authorized ranch personnel. We will be happy to escort visitors to meet the horses if time permits.

- Please leave your pets at home. Only **certified** service animals are allowed on the property.

- We at Queen of Hearts thank you for your cooperation. If you have any questions or concerns regarding the fee schedule or general rules, please feel free to speak with Executive Director, Robin Kilcoyne.

Queen of Hearts Therapeutic Riding Center, Inc.

6407 Dana Avenue, Jurupa Valley, California 91752 - (951-734-6300)

PARTICIPANT REGISTRATION AND HEALTH HISTORY

PLEASE FILL OUT ALL PAGES OF THIS APPLICATION AND RETURN TOGETHER AS A WHOLE PACKET

Participant Information:

Name: ____

Date of Birth:______________________ Age:_______ Gender:_______ Height:_________ Weight:__________

Address: ______________________________________City: _______________________ Zip:___________

Home Phone: ____________________Cell: ________________________ Email: ______________________

Medical Diagnosis: ____ Date Of Onset:________________

Seizures: Type _____________________________ Controlled? Yes: ___ No:___ Date of Last Seizure: ___________

Parent/Guardian and/or Emergency Contact:

Name: ____ Relationship: ____________________

Address (If Different From Above): ____

Home Phone: _____________________Cell: ________________________ Email: _________________________

Is this the Primary Billing Address? ____

Individual Responsible for Payment/Billing (If not listed above):

Name: ____ Relationship: ____________________

Address (If Different From Above): ____

Home Phone: ____________________Cell: ________________________ Email: _________________________

How did you hear about us?____

May We Put You On Our Mailing List? Yes ⬡ **No** ⬡

(We Do Not And Will Not Sell Or Give Away Your Information To Third Parties.)

Self-Report Health History - *Please indicate current or past problems in the following areas*:

	Y	N	COMMENTS
ALLERGIES			
BACK INJURIES/SCOLIOSIS			
BEHAVIORAL			
BONE/JOINT			
BREATHING			
CIRCULATION			
COMMUNICATION			
DIGESTION			
ELIMINATION			
EMOTIONAL			
FALL RISK?			
HEARING			
HEART			
LEARNING BARRIERS			
MUSCULAR			
PAIN			
SENSATION			
THINKING/COGNITION			
VISION			

CURRENT MEDICATIONS (including over-the counter): ____

____

PRECAUTIONS/RESTRICTIONS (Please indicate all implants, shunts, appliances, devices, etc.): ____________________________

____

____

DESCRIBE YOUR ABILITIES/DIFFICULTIES IN THE FOLLOWING AREAS (include assistance required or equipment needed):

Function (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding): __________________________

____

____

Social: (i.e. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.): ____

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Goals: (i.e. Why are you applying for participation? What would you like to accomplish?) _________________________

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Request for Services

No participant can be accepted for participation until the Parent/Guardian has completed this form. If the participant is at least 18 years old and mentally competent, he may complete the form himself. Every effort will be made to avoid any accident; however, NO LIABILITY can be accepted by any of the organization's trustees, agents, employees, each and every one of its members and associates, and the property owners upon whose land the lessons are conducted.

I would like (**enter participant's name**) ____ to participate in equine activities at Queen of Hearts Therapeutic Riding Center, Inc. I have discussed this with the child's (my) doctor. Furthermore, I grant permission to a Queen of Hearts' instructor or therapist to contact my doctor or therapist to further clarify medical information if needed (this information will be treated with confidentiality). I understand that NO LIABILITY can be accepted by any of the organizations concerned with this instruction or therapy, including QUEEN OF HEARTS THERAPEUTIC RIDING CENTER, INC., and QUEEN OF HEARTS RANCH. I understand that the final decision regarding acceptance, selected therapeutic activities, and continued participation rests with the Queen of Hearts' staff, upon due consideration of the individual's special needs and the safety of the participant, staff, volunteers, and horses.

Signature of Participant, Parent or Guardian (if under age 18) ____

____

Printed Name Date

* *

(Office use only) Date application received _______________________ Approved: __________________ Program Director

Queen of Hearts Ranch
Queen of Hearts Therapeutic Riding Center, Inc.
6405/7 Dana Avenue, Jurupa Valley, California 91752 - (951-734-6300)

RELEASE AND HOLD HARMLESS AGREEMENT

WARNING

Each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risk of equine activities.

The undersigned, _______________________________, fully understands that:

The program at QUEEN OF HEARTS RANCH and QUEEN OF HEARTS THERAPEUTIC RIDING CENTER, INC. (collectively, "QUEEN OF HEARTS"), provides therapeutic horseback riding and equine-assisted therapies and activities for able-bodied and disabled children and adults. Horseback riding and being around horses are considered a risk exercise, so volunteers and horses are carefully selected and trained, and safety equipment is required for all riders.

No participant will be accepted for equestrian services and no volunteer accepted until this form has been READ, UNDERSTOOD, COMPLETED and SIGNED by the parent(s) or guardian(s) of a minor, or if the participant or volunteer is of legal age and sound mind, by the participant or volunteer.

Although participation in the program is under strict supervision and every effort is made to avoid injury or accident, **the undersigned acknowledges the inherent risks involved in riding and working around horses**. This includes bodily injury from horseback riding or being in close proximity to horses. Among other risks, both horse and rider can be injured in normal use or in competition and schooling. In order to provide this valuable service, NO LIABILITY will be accepted by QUEEN OF HEARTS, or any of the organizations' officers, directors, instructors, personnel, volunteers or other persons connected with the above-named facility.

IN CONSIDERATION for the privilege of riding and/or working around horses at QUEEN OF HEARTS, the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, hold harmless and indemnify QUEEN OF HEARTS, its officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorney fees, which the undersigned or said minor may now or in the future have against QUEEN OF HEARTS, its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to QUEEN OF HEARTS, its officers, directors, trustees, agents, employees, representatives, successors or assigns, including but not limited to their negligence or gross negligence in rendering the services described above or in anyway incidental thereto.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE "RELEASE AND HOLD HARMLESS AGREEMENT".

Date: ___________________ Participant's Name: ____

Participant's Signature (if not a minor): ____

Print Parent's/Guardian's Name: ____

Parent's/Guardian's Signature: ____

Address: ____

City: ____ State:_______________ Zip:________________

PHOTO/MEDIA RELEASE

I _______ DO
_______ DO NOT

consent to and authorize the use and reproduction by QUEEN OF HEARTS RANCH, and/or QUEEN OF HEARTS THERAPEUTIC RIDING CENTER, INC. (collectively "QUEEN OF HEARTS") of any and all still and/or moving photographs and films, including television pictures, of my/our ☐SELF ☐CHILD ☐WARD, (**Enter Participant's Name**) ____ and consents and authorizes QUEEN OF HEARTS to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including, but not limited to, newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signature(s) to this release other than the intention of QUEEN OF HEARTS and its work.

Participant's Signature: ______________________________________ Date: _______________

Parent's/Guardian's Signature: ___________________________________ Date: ____________

Parent/Guardian Printed Name: ________________________ Relationship: ________________

* *

Optional Demographics

Because we are a nonprofit 501(c)(3) public entity and we have a strong desire to keep the costs of services as low as possible, we need to apply for grants. Most grants that we apply for are asking for the following demographic information that does not pertain to, nor influence, the services we provide our participants. However, because potential grantors request this information, it will help us to better represent those we serve. The following information is purely voluntary and does not influence acceptance into services at Queen of Hearts Ranch or Queen of Hearts Therapeutic Riding Center, Inc.

If you chose to answer, please check all answers that apply:

Ethnicity:

African/Black		Asian		Caucasian/White		European	
Hispanic/Latino		Multi - Race		Native American		Pacific Islander	
Other (Please Specify)				Unknown		Prefer Not to Answer	

Military/First Responder Status:

Military Active		Military Veteran		Firefighter Active		Firefighter Veteran	
Police Officer Active		Police Officer Veteran		EMT/Ambulance Active		EMT/Ambulance Veteran	
Emergency Medical Active		Emergency Medical Veteran		Other		Prefer Not to Answer	

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
~ PLEASE REVIEW CAREFULLY ~

EFFECTIVE JANUARY 1, 2023

1. **About Protected Health Information (PHI):**
   In this notice, “we,” “our,” or “us” means Queen of Hearts Therapeutic Riding Center, Inc. (Queen of Hearts) and our workforce of employees and volunteers. “You,” and “your” refers to each of our clients who are entitled to a copy of this notice.

   We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect health information about you in the manner that we describe here.

   Certain types of health information may specifically identify you. Because we must protect this health information, we call this “Protected Health Information,” or “PHI.” In this Notice, we tell you about:
   - How we use your PHI
   - When we may disclose your PHI to others
   - Your privacy rights and how to use them
   - Our privacy duties
   - Who to contact for more information or with a complaint.

2. **Some of the ways we use or disclose your PHI:**
   We will use your PHI to treat you. We are allowed to use or disclose your PHI for treatment, payment activities, and certain activities that we call “health care operations.” Health care operations involve a lot of the administration, education, and quality assurance activities at Queen of Hearts. Space in this document does not permit a complete list of all uses and disclosures. That is one reason why you can contact us and ask questions about how we use and disclose your PHI.

   a. Treatment
   We can use your PHI and disclose it to other professionals, therapists, staff, or volunteers in the course of your treatment. For example, we may need to explain to staff and volunteers a particular situation we need related to your overall condition to properly care for and treat you. We may disclose your PHI for many other types of treatment activities.

   b. Payment
   We can use and disclose your PHI in connection with payment for services, such as for billing or to get payment from health plans or other entities. For example, after we treat you, we will ask our administrator to bill you. We may use your PHI on the billing form for your purpose, which may be seen by administrators. We may use your PHI and share it with your insurance to fulfill requests from your insurer for what we did to treat you and the treatment notes and reports.

   c. Health Care Operations
   We can also use and disclose your PHI in our health care operations. For example, our care team meet to discuss particular client situations and may share PHI with each other for the purposes of education and collaboration to help them manage your treatment and services.

   d. Special Uses
   We may use and disclose your PHI for purposes that involve your relationship to us as a client. We may use or disclose your PHI to:
   - Provide you with appointment reminders.
   - Tell you about treatment alternatives and options.
   - Tell you in face-to-face communication about our other benefits and services.
   - Contact you to ask you to contribute to our charitable activities unless you tell us not to ask you. You will have the right to opt out of receiving such communications.

e. Disclosures to Relatives, Caregivers and Personal Representatives
Under appropriate circumstances and with appropriate authorizations, we may disclose your PHI to relatives, caregivers, friends, or personal representatives who are with you or contact us on your behalf. We may also need to notify such people of your condition in certain emergency or disaster relief situations. If you object to such disclosures, please notify us in writing at the address set forth in Section 7 below. Note, if you are not able to tell use your preference because, for example, you are unconscious or incapacitated, we may share your PHI if we believe it is in your best interest.

f. Research/Marketing
We may use and disclose limited information about you (but not including your name, address or other direct identifiers) for research, promotional and/or media-related uses, public health or health care operations, but generally, in a way the recipient of the information cannot directly identify you from the disclosed information.

However, in some situations, PHI may share for a purpose which requires your written authorization. In these cases, we will obtain your written authorization prior to sharing any such PHI and you will have the right at any time to revoke your authorization.

In addition to these uses, disclosures and cases of PHI summarized above in this Section 2 and below in Section 3, we may use or disclose your PHI either with your consent, written authorization, or as required or permitted by law. In all other uses, disclosures, or cases not described in Section 2 or Section 3, we will not use or disclose your PHI unless we receive written authorization from you that has specific instructions and limits on our use or disclosure of your PHI. If you later change your mind, you may revoke your authorization by providing written notice to the address set forth in Section 7 below.

3. **Certain uses and disclosures of your PHI that is required or permitted by law):**
Many laws and regulations apply to us that affect your PHI. These laws and regulations may either require us or permit us to use or disclose your PHI. You may have some rights to limit or restrict our ability to share PHI for the reasons described below. To communicate your preferences, you may contact us at the address listed in Section 7 below. From the federal health information privacy regulations, here is a list describing required or permitted uses and disclosures:
    - If you do not verbally object, we may include information identifying you on a schedule board posted each day, including only your name, required equipment and time you are scheduled.
    - If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
    - We may use your PHI in an emergency when you are not able to express yourself.
    - If we receive a certain assurance that protects your privacy, we may use or disclose your PHI for research.
    - When required by law, for example, when ordered by a court to turn over certain types of PHI, we must do so.
    - We may use your PHI for public health activities such as reporting a communicable disease, if possible, transmission occurs.
    - We may use your PHI to report neglect, abuse, or domestic violence.
    - We may use your PHI to report to government regulators or its agents to determine whether we comply with applicable rules and regulations.
    - We may use your PHI to report in judicial or administrative proceedings such as in response to a valid subpoena.
    - We may use your PHI to report if we reasonably believe that to do o will avert a health hazard or to respond to a threat to public safety such as an imminent crime against another person.

4. **Certain stricter requirements that we follow:**
Several state laws may apply to your PHI that set a stricter standard than the protections required by the federal health privacy regulations.
    - PHI regarding individuals who are the subject of HIV-related information.
    - Your medical information outside of Queen of Hearts except as provided by your written permission that is maintained by us in your record.
    - Your PHI to pursue a grievance against certain managed care organizations unless we have your written consent.
    - Records that contain alcohol and drug abuse information without your consent.
    - Your records without your consent or a court order if they contain information relating to inpatient mental health treatment or \involuntary outpatient mental health treatment.

5. Your privacy rights and how to exercise them:
The following section lists your specific rights with respect to your PHI under this federally required privacy program and how you may exercise those rights.

a. Your Right to Request Limited Use or Disclosure
You have the right to request that we limit or do not use or disclose your PHI for treatment, payment or health care operations. You also have the right to request a limit on PHI we disclose about you to relatives, caregivers, friends, or personal representatives that are involved in your care. All such requests must be made in writing and submitted to the address listed in Section 7 below.

To request a restriction, you must tell us the following information:

- What information you want to limit,
- Whether you want to limit or use a disclosure or both, and
- To whom you want the limits to apply (for example, disclosures to a relative).

We will consider your request carefully. However, we are not required to agree to your request (except in limited situations where the PHI is disclosed to another provider for emergency treatment). It is our general policy to not agree to request to limitation or prohibitions on using or disclosing PHI for treatment, payment or health care operations. IF we do agree to your request, we must abide by this agreement.

b. Your Right to Confidential Communication
You have the right to receive confidential communications from us at an alternative location or by alternative means of communication. Any request must be made in writing and submitted to the address identified in Sectio ny7 below. All written requests must include the requested alternate address and/or means of communication and explain to us if the request will interfere with your method of payment for your care.

c. Your Right to Revoke Your Consent or Authorization
If you have granted us your consent or authorization to use or disclose your PHI, you may revoke the consent or authorization in writing. However, if we have relied on your consent or authorization, we may use or disclose your PHI to that extent.

d. Your Right to Inspect and Copy
You have the right to inspect and copy your PHI, except for psychotherapy notes and information complied with in reasonable anticipation of, or for use of in a civil, criminal, or administrative action or proceeding. We also may refuse to give you access to our PHI if, upon review, we think it may cause you harm, or have another lawful basis to deny your request. However, we must explain to you the reason or reasons why your request was denied and give you someone to contact about our decision. All requests must be made in writing and sent to the address identified in Section 7 below.

e. Your Right to Amend Your PHI
If you disagree with what is said about you in your PHI that is in a record that we create or have maintained for us, (because, for example, you feel the PHI is incorrect or incomplete), you have the right to request, in writing, that we amend your PHI. You must submit a request to amend your PHI in writing to the address identified in Section 7 below. We are not required to respond to your request if the records you are asking about are not your records. Additionally, we are not required to amend your PHI if we determine the PHI is accurate and complete. In which case, we may refuse to make your requested amendment. Then, you will have a right to submit a written statement about why you disagree. If we still disagree, we may prepare a counter statement. Your statement and our counter statement must be made a pr of your record about you.

f. Your Right to Know who Sees your PHI
You have the right to request an accounting of certain disclosures that we have made of your PHI over the past six (6) years starting from the date you submit your request. You cannot ask for disclosures that occurred before April 14, 2003. We do not have to account for all disclosures, including but not limited to:

- Those involving treatment, payment, and heath care operation as described above;
- To you about your own health information;
- Those that are incident to a use or disclosure otherwise permitted;
- Made pursuant to your written authorization was provided; and
- To family relatives, caregivers , friends, or personal representatives involved in your care where your written authorization was provided.

There is no charge for an annual accounting but there may be for additional accountings. We will tell you if there is a charge for your accounting and you will have the right to withdraw your request, or to pay the charge and proceed with your request. Any request for an accounting should be made in writing and sent to the address identified in Section 7 below.

6. **Some of our privacy obligations and how we perform them:**
We are required to maintain the privacy of your PHI and comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you notice of our privacy practices. This document is our notice of our privacy practices. If you did not get a paper copy of this notice because you have previously agreed to receive the notice electronically, you may request to have a paper copy of this notice and we will provide one promptly. We will and are able to abide by the privacy practices set forth in this notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. We are also required to notify any affected individual following the breach of unsecured PHI.

If we change our notice of privacy practices, we will provide our revised notice to you when you visit us.

7. **Contact information:**
If you have questions about this Notice, please contact:
Queen of Hearts Therapeutic Riding Center, Inc.
6407 Dana Ave.
Jurupa Valley, CA 91752

8. **Effective Date:**
January 1, 2023

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Please sign and date below and return it to indicate that you have received a copy of this Notice of Privacy Practices. Your signature simply acknowledges that you received a copy of this Notice.

Participant's Name: ____
Participant's Signature ____ Date: __________________

(If participant is a minor):

Print Parent's/Guardian's Name: ________________________________

Parent's/Guardian's Signature: __________________________________ Date: __________________

Queen of Hearts Ranch
Queen of Hearts Therapeutic Riding Center, Inc.
6405/7 Dana Avenue, Jurupa Valley, California 91752 - (951-734-6300)

PARTICIPANT/CLIENT GRIEVANCE/COMPLAINT POLICY

A grievance (or complaint) is defined as a contention of misapplication, violation, or inequitable application of Queen of Hearts Therapeutic Riding Center's policies and/or applicable laws. This policy applies to all participants/clients, and they are given information regarding how to file a grievance/complaint in their application packet and it is reviewed at their Intake Assessment.

All grievances or complaints must be in writing and must state clearly and concisely all the known facts related to the grievance, including "who, what, where, when, and why," and should clearly explain why the individual disagrees with the act or omission that forms the basis of the grievance. The grievance must include the requested remedy and be signed and dated. One who wishes to file a formal complaint should proceed with the following steps in order in which they are listed. The goal of this process is to resolve the complaint as promptly as possible.

Step 1. An attempt will be made to settle all complaints by oral discussions between the complainant and the person to which the complaint is alleged.

Step 2. If the matter cannot be resolved informally with person to which the complaint is alleged, the complainant should submit a written complaint to the Executive Director within thirty (30) days from the date the conflict was identified or should have been identified. A copy of this complaint may be given to the person to which the complaint is alleged. The written complaint should include the following: a description of the complaint, the date(s) it occurred, the people involved, Queen of Hearts' policy or applicable law which has allegedly been misapplied or violated, and the desired remedy. Names of witnesses and any evidence should be included. The complainant should present the grievance in a confidential manner to the Executive Director.

The Executive Director will endeavor to investigate the complaint and respond in writing to the complainant within ten (10) working days from the filing of the complaint. The investigation may include a verbal discussion with the person filing the complaint. The response generally will be presented to the complainant in a meeting with the Executive Director to facilitate discussion and clarity around the decision. A copy of this response may also be given to the person to which the complaint is alleged.

Step 3. If the complainant is not satisfied with the Executive Director's response, the complainant may refer the grievance to the Chair of the Board of Directors or a designated representative. Such referrals should be made within five (5) working days of the Executive Director's response. A copy of the complaint should also be given to the Executive Director and the Chair of the Board of Directors. Investigation and resolution of the complaint will generally be carried out by the Board of Directors which should include no fewer than three Board Directors. The Board's review may include, at the request of any party, meetings with the complainant and the Executive Director. The Board of Directors will endeavor to provide a written response to the complainant within thirty (30) days of receiving the complaint and may present this response in a meeting with the complainant and the Executive Director.

If a complainant fails to comply with the suggested time frames, the grievance is considered to be dropped. If management fails to comply with the suggested time frames, the complainant may proceed with the next step.

Matters concerning complaints will be kept as confidential as possible, consistent with Queen of Hearts' need to investigate and act on complaints. A complaint instituted against a staff member will be placed in the staff member's personnel file along with the outcome. It is not considered proper if the one abuses the procedure by raising complaints in bad faith or solely for the purposes of delay or harassment or by repeatedly raising complaints that a reasonable person would judge to have no merit.

Final decisions on complaints will not be precedent setting or binding on future complaints. The Board of Directors has discretion to reach different conclusions in different situations.

PARTICIPANT/CLIENT GRIEVANCE/COMPLAINT POLICY ACKNOWLEDGEMENT

Please sign and date below and return it to indicate that you have received a copy of this Participant/Client Grievance/Complaint Policy. Your signature simply acknowledges that you received a copy of this Notice.

Participant's Name: ____

Participant's Signature ____ Date: ___________________

(If participant is a minor): Print Parent's/Guardian's Name: ____

Parent's/Guardian's Signature: ____________________________________ Date: ___________________

Possible Reasons for Discontinuation of Participant/Client Services

Please be advised of the following reasons that may lead to discontinuation of services from Queen of Hearts Therapeutic Riding Center, Inc. The duration of services is variable and is determined by each instructor or therapist. If the instructor or therapist deems discontinuation of current services is necessary, then options to transfer to other services may be offered, or the participant/client may be declined services at Queen of Hearts Therapeutic Riding Center, Inc. entirely.

Potential reasons for internal transfer or discontinuation of services include, but are not limited to:

- When the participant/client's anticipated goals and expected outcomes have been met.
- Service is contraindicated because of a change in medical, physical, cognitive, or emotional condition that makes equine-assisted services inappropriate.
- A participant/client's potential to maintain head and neck control in a sitting position presents a safety concern.
- Participant/client consistently demonstrates behaviors that inhibit progress towards goals, such as participant/client is disrespectful, or violent to self or others, lack of cooperation, motivation, or chronic absenteeism.
- Participant/client is unable to follow directions and this inability is interfering with progress towards goals or presents a safety concern.
- Queen of Hearts may no longer have appropriate/available equine or equipment to safely conduct sessions for the participant/client.
- Participant/client's weight exceeds weight that can safely be managed by staff, volunteers, and/or horses.
- Scheduling conflicts.
- Participant/client has outdated medical or personal information.
- There is a 30-day delinquent payment owed by participants/clients. (This does not pertain to 3rd party payers.)
- Participant/client has 2 or more unexcused absences or no-shows during a 4-week session period and no time slots are available for make-up sessions.
- The participant/client/family/conservator chooses to discontinue services.
- The participant/client's needs are better served by an alternate program and/or service.
- Based upon professional staff judgment, it is determined that the participant/client will no longer benefit from receiving equine-assisted services.

Queen of Hearts Therapeutic Riding Center, Inc.

A Non-Profit Equine-Assisted Therapy Program for People with Special Needs
CA Organization No. 2231279 ~ Federal 501(c)(3) EIN 33-0907556 ~ Duns 030638451
Where the Riding Spirit Comes from the Heart

6407 Dana Avenue
Jurupa Valley, CA 91752 -2427
(951) 734-6300
www.queenofheartsranch.org

PATH Intl Premier Accredited Center No. 43710
PATH Intl Certified Therapeutic Riding Instructors
PATH Intl Certified Equine Specialists
EAGALA Advanced Certified Facilitators
VA/RII Certified Peer Support Specialists

Dear Health Care Provider:

One of your patients is interested in supervised equestrian activities. Enclosed is an assessment form which will help our therapists and instructors develop a safe and effective riding program for him/her. Please fill out the areas that pertain to your expertise, and/or attach any existing assessments or reports that you think will be helpful to our staff.

To safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Adaptive horseback riding is a unique and productive way to improve the quality of life for many children and adults with physical, cognitive, or psychological disabilities. Queen of Hearts Therapeutic Riding Center, Inc. serves many such people each week from within the Inland Empire and beyond. Your participation in our program is invited. Please feel free to call or visit if you would like more information.

Precautions and Contraindications

Orthopedic
Atlantoaxial Instability – include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydroxylian

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e., Photosensitivity
Poor Endurance
Skin Breakdown
Weight Considerations (For the health and safety of our horses and volunteers, we may not be able to accept riders who weigh over 200 pounds.)

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding your client's participation in equine-assisted activities, please contact the center at the address/phone indicated above.

Queen of Hearts Therapeutic Riding Center, Inc.
6407 Dana Avenue, Jurupa Valley, California 91752, (951) 734-6300

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant: ____

DOB: _______________________ Age:_________ Sex:_________ Height:__________ Weight_________

Address: ____City: _____________________Zip:__________

Diagnosis: ____ Date Of Onset: ____________________

For those with Down Syndrome: Cervical X-Ray for Atlanto-Axial Instability:
Positive _______ Negative_______ X-Ray Date_______________________

Tetanus shot: Yes ◯ No ◯
Date: ____________________

Seizures: Type ____________________________ Controlled? Y N Date of Last Seizure: _________

Medications: ____

HEALTH HISTORY: *Please indicate current or past problems in the following areas, including surgeries:*

	NORMAL	PROBLEMS/DEFICITS	COMMENTS/SURGERIES
ALLERGIES			
AUDITORY			
BACK INJURIES/SCOLIOSIS **type/degree**			
BALANCE			
BEHAVIORAL			
CARDIAC			
CIRCULATORY			
COGNITIVE			
EMOTIONAL/PSYCHOLOGICAL			
IMMUNITY			
LEARNING DISABILITY			
MUSCULAR			
NEUROLOGICAL			
ORTHOPEDIC			
PULMONARY			
RESPIRATORY			
TACTILE SENSATION			
VISION			
SHUNT	YES:	NO:	
GI TUBES	YES:	NO:	
CATHETER	YES:	NO:	
OTHER			

MOBILITY:
INDEPENDENT AMBULATION Y____ N ____ BRACES Y____ N ____ CRUTCHES Y____ N ____ WHEELCHAIR Y____ N ____
OTHER SPECIAL PRECAUTIONS/RESTRICTIONS: ____

This Form MUST BE Signed by a Physician

I have reviewed the CONTRAINDICATIONS attached to this form. In my opinion, this patient has none of these contraindications and may participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the participant to a PT/OT/ or SLP or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program. I understand that the final decision regarding acceptance rests with the Queen of Hearts Therapeutic Riding Center, Inc. staff, upon due consideration of the participant's special needs, precautions and contraindications, and the safety of the participant, staff, volunteers, and horses.

PHYSICIAN'S NAME (please print) ______________________________ LICENSE/UPIN NUMBER: _______________
PHYSICIAN'S SIGNATURE: ____ Date: _______________
Address: ____ Phone: (____) ________________

MAY WE PUT YOU ON OUR MAILING LIST? Yes: ___ No: ___
(WE DO NOT & WILL NOT SELL OR GIVE AWAY YOUR INFORMATION TO THIRD PARTIES)