

# WE CAN RIDE



P.O. Box 1102  
MINNETONKA, MN 55345  
(952) 934-0057  
WWW.WECANRIDE.ORG

DATE RECEIVED \_\_\_\_\_

## CLIENT REGISTRATION

### CLIENT INFORMATION

NAME \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_ DATE OF REGISTRATION \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

PARENT/GUARDIAN NAME (IF APPLICABLE) \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

CONTACT: HOME \_\_\_\_\_ WORK \_\_\_\_\_

CELL \_\_\_\_\_ EMAIL \_\_\_\_\_

PREFERRED NUMBER \_\_\_\_\_

GROUP HOME NAME (IF APPLICABLE) \_\_\_\_\_

GROUP HOME ADDRESS \_\_\_\_\_

GROUP HOME PHONE \_\_\_\_\_ GROUP HOME FAX \_\_\_\_\_

EMERGENCY CONTACT: NAME \_\_\_\_\_ PHONE \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

DATE OF ONSET \_\_\_\_\_

EFFECT(S) OF DIAGNOSIS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SPECIAL ASSISTANCE NEEDED TO SIT, STAND, MOVE, OR COMMUNICATE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

GENERAL BEHAVIOR: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE COMPLETE & SIGN OTHER SIDE**

# CLIENT REGISTRATION

(CONTINUED)

## CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the release of information from the following sources to *We Can Ride, Inc.*:

### MEDICAL HISTORY

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

### THERAPY PROGRAM(S)

THERAPIST \_\_\_\_\_ PHONE \_\_\_\_\_

### SCHOOL OR RESIDENTIAL FACILITY

FACILITY \_\_\_\_\_ PHONE \_\_\_\_\_

SIGNATURE OF RELEASE  \_\_\_\_\_ DATE \_\_\_\_\_  
RELATIONSHIP TO CLIENT \_\_\_\_\_

## LIABILITY

As a client with *We Can Ride, Inc.*, I acknowledge the risks and potential for risks of horse-related activities; however, I feel that the possible benefits to the Client are greater than the risks assumed. I hereby intend to be legally bound for the Client, myself, heirs and assigns, executors or administrators, waive and release forever all claims for damages against *We Can Ride, Inc.*, its Board of Directors, staff, consultants, and volunteers, but not limited thereto, for any and all injuries and/or losses which may be sustained while participating in *We Can Ride, Inc.*

SIGNATURE OF RELEASE  \_\_\_\_\_ DATE \_\_\_\_\_  
RELATIONSHIP TO CLIENT \_\_\_\_\_

## CONFIDENTIALITY

Clients, donors, We Can Ride Employees, Hennepin County Home School Residents, parents/guardians/attendees of Clients, visitors, and volunteers (herein "WCR Affiliates"), are prohibited from knowingly or willingly disclosing confidential information regarding any other WCR Affiliates. All documents, files, and working papers of *We Can Ride, Inc.* are the property of *We Can Ride, Inc.* and under no circumstances is information concerning any of the WCR Affiliates to be revealed to third parties, except as approved by the *We Can Ride, Inc.* Board of Directors or a Release signed by a specific WCR Affiliate.

Further, it is a misdemeanor to violate the confidentiality of Residents at the Hennepin County Home School, their identity, residency, and/ or their juvenile court record, and there are legal consequences for violation. In addition, the Hennepin County Home School can or will deny access to their property and the *We Can Ride, Inc.* program.

WCR Affiliates are cautioned to exercise care not to disclose confidential information unintentionally, by indiscreet conversations or by careless handling of sensitive documents. For purposes of this Confidentiality Agreement, "confidential information" means any information contained in a personnel record, client file, donor record, financial documents, Hennepin County Home School record, volunteer paperwork, and also includes internal discussions about WCR Affiliates, and/or any written information. WCR Affiliates who violate this policy, either purposely or through a failure to exercise reasonable care, are subject to disciplinary action up to and including immediate dismissal.

SIGNATURE OF RELEASE  \_\_\_\_\_ DATE \_\_\_\_\_  
RELATIONSHIP TO CLIENT \_\_\_\_\_

## BILLING

I understand that medical insurance policies are an arrangement between an insurance carrier and myself. I further understand that charges for some services may be more than what some insurance companies will cover. I hereby acknowledge that I am ultimately responsible for all charges applied to my account.

SIGNATURE OF PAYOR  \_\_\_\_\_ DATE \_\_\_\_\_