



MYHEROES, LLC.

OVERCOMING OBSTACLES, ONE HOOF AT A TIME

DATE: (mm/dd/yyyy)	
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CLIENT INFORMATION					
First Name		Middle Initial		Last Name	
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	DOB (mm/dd/yyyy)			
Height:	Weight:		Pronouns (optional):		
Diagnosis	Primary:		Secondary:		
Primary Email			Primary Phone		
Street Address			City		
State			Zip Code		

PARENTS/GUARDIANS (if patient not an adult or considered a dependent)					
Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/>					
Parent Name		Parent Name			
Parent Cell Phone		Parent Cell Phone			

EMERGENCY CONTACTS					
Name		Relation		Phone	
Name		Relation		Phone	

PHYSICIAN INFORMATION					
Primary Physician					
Physician Name		Doctor's Group			
Office Address					
Phone		Fax			



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YOU OR YOUR CHILD'S MEDICAL HISTORY IN YOUR OWN WORDS

GOALS/EXPECTATIONS

What do you hope to achieve through our services? What goals would you love to see accomplished in:

3 months?

6 months?

1 year?

Is there anything else you would like us to know about you or your child?

HORSEMANSHIP AND RIDING ABILITIES

Please describe you or your child's experience with horses, including horsemanship skills, groundwork, riding abilities, etc:



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CLIENT MEDICAL HISTORY					
Condition	Yes	No	Condition	Yes	No
Abnormal Fatigue			Hydrocephalus		
Acute Arthritis			Incontinence		
Acute Herniated Disk			Loss of Sensation		
Agitation with Severe Confusion			Multiple Sclerosis, Acute		
Allergies			If yes, please list allergies:		
Aneurysm			Open Wounds		
Arnold Chiari Malformation			Osteogenesis Imperfecta		
Audible Aspiration			Osteoporosis		
Cardiac/Heart Condition			Obesity Problems		
Circulation Problems			Recent Dorsal Rhizotomy		
Complete Quadriplegia			Scoliosis Greater than 30 Degrees		
Degeneration of Hip Joint			Seizure Disorder		
Diabetes			Shunt(s)		
Excessive Swayback/Hunchback			Spinal Fusion		
Grafts Over Bony/Weight Bearing Areas			Spondylolisthesis		
Head Injury			Silent Aspiration		
Hearing Problems			Substance Abuse		
Hemophilia/Blood Disorder			Tethered Cord		
Heterotrophic Ossification			Unstable Neck or Spine		
Hip Dislocation, Subluxation, or Dysplasia			Vision Problems		
History of Skin Breakdown			If yes, please explain:		
History of Seizure			If yes, please explain:		

Mailing Address: 316 S Washington Ave, Fort Collins, CO 80521
 Service Address: 725 S Overland Trail, Fort Collins, CO 80521
 brentaplegate@myheroestherapy.com

p) 678-984-7774
 f) 888-551-6210
 www.myheroestherapy.com



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SPECIFIC TO DOWN SYNDROME

All riders with Down Syndrome must be examined by a physician knowledgeable about Atlantoaxial instability (AAI). The exam must include full extension and flexion x-rays of the neck. The results of the x-ray and examination must demonstrate that the individual does not have the Atlantoaxial instability condition. The rider with Down Syndrome must also annually provide information from his/her physician clearly indicating the absence of neurologic symptoms by clinical exam.

Date of most recent x-ray and neurologic exam? (mm/dd/yyyy)

Negative cervical x-ray for atlantoaxial instability?

Yes

No

Neurologic symptoms of AAI present?

Yes

No

MEDICATIONS

Name	Dosage	Frequency	Reason

ANY PAST MEDICATIONS WE SHOULD BE AWARE OF

WARNING: Colorado - Warning - Under Colorado Law, an equine professional is not liable for the injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to section 13-21-119, Colorado Revised Statutes.

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CANCELLATION POLICY

We realize that illnesses, emergencies, and other scheduling conflicts arise and are sometimes unavoidable. However, advanced notice allows us to fulfill other patient's scheduling needs and keeps the program operating at its most efficient level. Last minute cancellations have once again become an increasingly common concern among therapy and adaptive riding sessions, and starting on January 1, 2024, My Heroes will be implementing the following changes to our cancellation policy.

All policies will be effective on a semester-based session schedule:

- Fall Session: ~August 15 - December 31
- Spring Session: ~January 1 - May 15
- Summer Session: ~May 16 - August 14

Any known cancellations communicated ahead of the start of the semester will be fully excused, so please communicate with your therapist or program director as soon as possible!

Cancellation Fee Schedule		
	With 24hrs Notice	Without 24hrs Notice
1st Cancel	No charge	No charge
2nd Cancel	\$25	\$40
3rd Cancel	\$40	\$65
No Call/No Show	\$65	

All cancellation fees will be billed directly to the family or client, as My Heroes is unable to bill insurance, Medicaid, FSSP, or Medicaid waivers for these fees.

My Heroes reserves the right to cancel sessions in the event of unsafe conditions. We may cancel when Larimer County is on accident alert status or when weather or driving conditions have the potential to become dangerous. We may cancel classes in extreme heat (above 95 degrees or when the heat index reaches over 130), extreme cold (below 15 degrees), extreme winds, or dangerous thunder and lightning storms. We will make every effort to contact you in a timely manner if a cancellation is deemed necessary. Clients are responsible for supplying us a working, text-capable phone number so that we may contact you urgently.

If the client's assigned therapist is unable to make it to their scheduled appointment(s), My Heroes will try to find an alternate therapist or will try to reschedule the appointment if availability aligns with current openings. Cancellations fees do not apply if we are unable to accommodate the client with an alternate therapist or rescheduled appointment. If you or your child have any concerns with meeting the updated cancellation policies, please discuss a plan of action with your assigned therapist or the Program Director. We appreciate your understanding as we all navigate through these new policies.

Parent/Guardian Signature		Date	
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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the following Person(s) or Facility(ies) to release information from the records of (you or your child's name) _____ DOB: _____ :

- 1) Person(s) or Facility(ies):
- 2) Person(s) or Facility(ies):
- 3) Person(s) or Facility(ies):
- 4) Person(s) or Facility(ies):

The information is to be released to My Heroes, llc and any of the instructors working under the auspices of My Heroes, llc for the purpose of adaptive riding services provided under My Heroes, llc. The information to be released is indicated below:

- Medical History
- Physical/occupational/speech therapy evaluation, assessment, and treatment plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (IHP)
- Classroom Individual Education Plan (IEP)
- Psychosocial evaluation, assessment, and treatment plan
- Cognitive-behavioral management plan
- Other relevant information pertaining to the client being treated at My Heroes, llc

The release is valid for one year and can be revoked, in writing, at my request.

Parent/Guardian Signature		Date	
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PHOTO RELEASE

I DO
DO NOT

consent to and authorize the use and reproduction by My Heroes, llc and/or the Temple Grandin Equine Center of any and all photographs and any other audio/visual materials taken of me or my child for promotional material, educational activities, exhibitions, social media use, or for any other use for the benefits of the above mentioned programs.

Parent/Guardian Signature		Date	
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CONFIDENTIALITY AGREEMENT

I understand that all the personal information (written and verbal) about participants at My Heroes, llc is confidential and not to be shared with anyone without expressed written consent of the participant or their parent/guardian if a minor.

Parent/Guardian Signature

Date

CONSENT FOR PAYMENT

Payment Policy: All payments will be accepted through Quickbooks secured billing services. You will be sent an invoice to your email on file with a link to set up and pay using their secured server. You can use any credit or debit card you like. Please let us know if this payment method does not work for you for any reason so that we can set up an alternative solution.

I understand the hourly rate for adaptive riding is \$65 /session at Colorado State University/Temple Grandin Equine Center. I understand a yearly evaluation will be performed. I have read the above information regarding payment for adaptive riding services by My Heroes, llc. and fully understand this information. I authorize Brent Applegate, MPT, owner, or their billing agent, to bill me or my appropriate third party payer for direct reimbursement of adaptive riding services rendered to me or my child. I understand that services will be put on hold, if I fail to reimburse in a timely fashion. I will inform the provider of any changes in applicable third party payer(s) that may occur.

Parent/Guardian Signature

Date

RELEASE AND INDEMNIFICATION AGREEMENT

Whereas, My Heroes, llc., d/b/a Brent Applegate has made available to the undersigned, or to the child of the undersigned, or both, all or a portion of the property, equipment and facilities of My Heroes, llc., Brent Applegate, Colorado Sate University, Temple Grandin Equine Center, or any other location, including but not limited to, riding areas, stables, equipment, and horses, the undersigned hereby assumes full responsibility for the safety of the Rider. The term Rider shall mean not only the undersigned, but also, any minor of the undersigned, and also any person who uses any portion of the property, equipment, horses or facilities of My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, with permission of the undersigned. Undersigned hereby releases My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, any landowner, their agents, employees, contractors, successors, assigns, legal representatives, heirs, executors and administrators from any and all claims, causes of action, demands, obligations and liabilities – which are now existing or hereafter mature or accrue at any time – arising out of or related in any fashion to Rider’s uses of My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, property, equipment or facilities, except for My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location gross negligence or My Heroes, llc. intentional acts. The undersigned acknowledges and fully understands that the Rider uses the property, equipment and facilities of My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location at his or her own risk. The undersigned hereby agrees to hold and save My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, any landowner, their agents, employees, contractors, successors, assigns, legal representative, heirs, executors and administrators harmless from each and every claim, demand, liability, or other obligation which may arise out of or be connected in any fashion with loss, injury or damage to the Rider or to the Rider’s property. The undersigned hereby agrees and covenants not to bring any action at law or in equity against My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other



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location, any landowner, their agents, employees, contractors, successors, assigns, legal representative, heirs, executors or administrators on behalf of the undersigned or on behalf of Rider, whether minor or adult, arising from or relating in any fashion to any injury, damage or other loss suffered by Rider and connected in any fashion with Rider's use of My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center or any other location, property, horses, equipment or facilities; and the undersigned shall further defend My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center or any other location, any landowner, their agents, employees, contractors, successors, assigns, legal representative, heirs, executors and administrators against any such actions brought by Rider or on Rider's behalf with respect to the Rider's uses of My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location property, horses, equipment or facilities and the undersigned shall indemnify My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, their agents, officers, directors, employees, contractors, successors, assigns, legal officers, directors, employees, successors, assigns, legal representatives, heirs, executors and administrators for anything for which Rider is responsible either alone, jointly or severally. The undersigned hereby acknowledges and understand that My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, their agents, employees, successors, assigns, legal representative, heirs, executors and administrators do not represent or warrant the quality or character of any horse furnished to Rider. Furthermore, the undersigned acknowledges and understands that horseback riding or other participation in activities at My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, may involve substantial risk of bodily injury, property damage and other dangers including, but not limited to, bodily injury or death resulting from kicks and bites, falling off horses or horses falling on Rider, being dragged by a foot caught in the stirrups, Rider being thrown by horse, equipment failure or collision with horses or vehicles or other inanimate objects.

The term "Rider" shall include (Rider's name here) _____ DOB: _____

In the event Rider or any other the designated individuals is a minor, the undersigned, on behalf of said minor, does hereby consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or specific instructions of any physician or hospital. The undersigned acknowledges that this consent to treatment which may be required, but is given to encourage My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, any hospital staff and physicians to exercise their best judgment as to the requirements of such diagnosis or treatment. The undersigned hereby agrees to pay all fees and expenses of doctors, hospitals, ambulances and other medical expenses reasonably and necessarily incurred.

READ CAREFULLY BEFORE YOU SIGN. THIS DOCUMENT RELEASES MY HEROES, LLC., BRENT APPLGATE, COLORADO STATE UNIVERSITY, TEMPLE GRANDIN EQUINE CENTER OR ANY OTHER LOCATION, FROM ANY LIABILITY RESULTING FROM USE OF MY HEROES, LLC., BRENT APPLGATE, COLORADO STATE UNIVERSITY, TEMPLE GRANDIN EQUINE CENTER OR ANY OTHER LOCATION, PROPERTY, EQUIPMENT OR FACILITIES.

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Parent/Guardian Signature		Date	
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