Morning Dove Therapeutic Riding Inc.
PO Box 721, Zionsville, IN 46077
Telephone (317) 733-9393
e-mail: Brad@mdtrc.org

PARTICIPANT INFORMATION

Music Therapy @ Morning Dove

General Information:

Name ______________________________ Date ____________

Age ______ Home Phone ______________ Work/Cell Phone ____________

Address ______________________ City __________ Zip Code ______

Email Address __________________ Employer/School: ________________

Job title: ____________________

Parent (if under 18)/Legal Guardian/Caregiver name: ____________________

Address (if different from above): ______________________________

EMERGENCY RELEASE

Physician's Name________________ **Physician's Phone** ________________

Who can we call in the case of an emergency?

Name________________ Phone ____________ Relationship __________

Name________________ Phone ____________ Relationship__________

In case of medical emergency, the undersigned authorizes Morning Dove Therapeutic Riding Inc. to provide such medical assistance as they determine to be necessary. The undersigned authorizes any licensed physician and / or medical facility to provide any medical / surgical care and / or hospitalization for the rider, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned.

No person can be accepted for program participation until this form has been completed. If the person is of legal age (18), he or she may complete the form, if he or she is legally competent to do so; otherwise it must be signed by the parent / parents or guardian. All activities will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including Morning Dove Therapeutic Riding Inc..

______________________________ ______________________________

SIGNATURE OF PARTICIPANT IF OVER AGE 18 *SIGNATURE OF PARENT / PARENTS OR GUARDIAN*

MORNING DOVE
THERAPEUTIC RIDING INC

MUSIC PREFERENCE SURVEY

Clients Name: ____ Date: ________________

1. **Preferred musical style (Examples – Rock, Disney, Classical, Radio)**:

   ____

   ____

   ____

   ____

2. **Preferred music artists**:

   ____

   ____

   ____

   ____

3. **Favorite Songs**:

   ____

   ____

   ____

   ____

4. **Access to music listening (Examples – Radio, IPad, CD player, Car rides)**:

   ____

   ____

   ____

   ____

5. **Music activities (Past or present participation)**

   ____

   ____

   ____

   ____

Morning Dove Therapeutic Riding Inc.

LIABILITY RELEASE AGREEMENT – *MUSIC THERAPY PARTICIPANT*

The undersigned, as the parent/guardian of the participating minor child, ____________________, for and in consideration of the agreement with Morning Dove Therapeutic Riding Inc. to participate in activities at Morning Dove does/do hereby forever release, acquit, discharge and hold harmless Morning Dove Therapeutic Riding Inc., its officers, trustees, agents, employees, representatives, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned or said minor may now, or in the future, have against Morning Dove Therapeutic Riding Inc. its officers, trustees, agents, employees, representatives, successors and assigns, on account of any personal injuries, physical or mental condition, known or unknown, to the undersigned and the treatment therefore as a result of, or in anyway growing out of, the acts of Morning Dove Therapeutic Riding Inc., its officers, trustees, agents, employees, representatives, successors and assigns including but not limited to, their negligence or gross negligence, in rendering the services above described or in anyway incidental thereto. Under Indiana law (Indiana Code 34-31-5) an equine professional is not liable for an injury to, or the death of a participant in equine activities resulting from the inherent risks of equine activities.

I have read and understand this release. Please sign and date:

Signature: ____________________ **Date:** ____________

(Parent/Guardian signature)

WITNESSED: ____________________ **Date:** ____________

(Staff Signature)

<u>PHOTO RELEASE FORM</u>

Music Therapy @ Morning Dove

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants ____ /does not grant ____ to Morning Dove Therapeutic Riding Inc. (MDTRC) permission to take or have taken, still and moving photographs and films including television pictures of ____ and consents and authorizes MDTRC, its advertising agencies, news media, and any other persons interested in MDTRC and its work, to the use and reproductions of the photographs, films, and pictures to circulate and publicize the same by all means including without limit, the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material. With regard to the foregoing material, no inducements or promises have been made to us / me to secure our / my signature(s) to this release other than the intention of MDTRC to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding its program and its work.

I have read and understand this release.

Signature: ____**Date:** ____________________

(parent/guardian signature)

Notice of Privacy Practices
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION: PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY
   Morning Dove is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we must follow.
   We realize that these laws are complicated, but we must provide you with the following important information:
   - How we may use and disclose your IIHI
   - Your privacy rights in your IIHI
   - Our obligations concerning the use and disclosure of your IIHI

   The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.
B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Morning Dove INC.
C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS
D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
   The following categories describe unique scenarios in which we may use or disclose your identifiable health information:
   1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
      a. Reporting child abuse or neglect
      b. Preventing or controlling injury or disability
      c. Notifying individuals if a product or device they may be using has been recalled
      d. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
   2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
   3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute. Our relationship with you does not confer any doctor/patient or similar privilege against disclosure.
   4. Law Enforcement: We may release IIHI if asked to do so by a law enforcement official:
      a. Regarding a crime violation in certain situations, if we are unable to obtain the person's agreement
      b. Concerning a death we believe has resulted from criminal conduct
      c. Regarding criminal conduct at our office or at the individuals residence during treatment
      d. In response to a warrant, summons, court order, subpoena or similar legal process
      e. To identify/locate a suspect, material witness, fugitive or missing person
      f. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
   5. Deceased Patients. Our practice may release IIHI if requested by a government official.
   6. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or

written agreement of a researcher that (i)the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researchers agree either orally or in writing that the use or disclosure is necessary for the research and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

7. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
8. Military. Our practice may disclose you IIHI if you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
9. National Security. Our practice may disclose you IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
10. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals
11. Workers' Compensations. Our practice may release your IIHI for workers' compensation and similar programs.
12. Parent or legal guardian or other disclosed person. We may disclose information to any other parent or legal guardian of the patient, or to the following persons who you are specifically designating to receive this information:
13. Any other person or organization who you may authorize us to provide information to, if that authorization is in writing and is dated and signed by you.
14. Your primary care and/or your referring specialist.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Morning Dove Inc. specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Morning Dove Inc. Your request must describe in a clear and concise fashion: The information you wish restricted: Whether you are requesting to limit our practice's use, disclosure or both; and to whom you want the limits to apply.
3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Morning Dove Inc. in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Upon receipt of this written request, Morning Dove Inc. has 5 business days to comply with your request.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request in writing and submitted to Morning Dove, Inc. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain nonroutine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, a music therapist sharing information with another contracted music therapist in the practice; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing Morning Dove Inc. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before November 1st, 2006. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice or privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Morning Dove Inc.
7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Moring Dove Inc. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice of our health information privacy policies, please contact Morning Dove Inc.

I authorize Morning Dove Inc. to have access to confidential information as it is relevant to the treatment of the individual. I understand that Morning Dove Inc. upholds all confidentiality standards as required by HIPAA.

Signature of Legal Guardian______________________________ Printed name __________________________

Client's Name ____ Date _________________________________

2021PROPERTY OWNER RELEASE AND WAIVER OF LIABILIITY AND HOLD HARMLESS AGREEMENT

IN CONSIDERATION of being permitted to enter into property owned by Fortune Development, LLC and operated by Morning Dove Therapeutic Riding, Inc. (hereinafter the "Farm") for any purpose, including but not limited to, horseback riding, other equine activities, observation, use of facilities or equipment, or participation in any way, the undersigned, for himself or herself and any personal representative, administrator, executor, heir, family member, successor and assign, hereby acknowledges, agrees and represents that he or she has, or immediately upon entering will, inspect such premises and facilities. It is further warranted that such entry into the Farm for horseback riding, other equine activities, observation, participation or use of any facilities or equipment constitute an acknowledgement that such premises and all facilities and equipment thereon have been inspected and that the undersigned finds and accepts same as being safe and reasonably suited for the purposes of such observation or use.
IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE FARM FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO, HORSEBACK RIDING, OTHER EQUINE ACTIVITIES, OBSERVATION, USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY WAY, THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING.

1. THE UNDERSIGNED HEREBY ACKNOWLEDGES that horses may, without warning, kick, bite, balk, stomp, stumble, rear, bolt, fall down, and react to sudden movements, noise, light, vehicles, other animals or objects. Equestrian activities involve equipment that may break, fail or malfunction. Other riders may not control their animals, or ride within their ability, and cause a collision or other unpredictable consequences. Equestrian activities may be conducted in areas which are subject to constant change in condition according to weather, temperature, and natural and man-made changes in the landscape, including the riding ring, where objects are not marked and hazards may not be visible; where trails are not groomed, maintained or controlled; where weather is changeable, unpredictable and dangerous; and where lightning, thunder, beehives, streams, creeks, fallen timber, wild animals and other hazards and dangers exist.
2. THE UNDERSIGNED HEREBY RELEASES, WAIVES DISCHARGES AND COVENANTS NOT TO SUE EITHER FORTUNE DEVELOPMENT, LLC OR MORNING DOVE THERAPEUTIC RIDING, INC., its trustees, directors, members, managers, officers, employees, and agents (hereinafter referred to as the "indemnified parties") from all liability to the undersigned, his or her personal guardians, representatives, administrators, executors, heirs, family members, successors and assigns for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligent act or omission of the indemnified parties or otherwise while the undersigned is in, upon, or about the farm or any facilities or equipment therein. In the event that an attorney is engaged to enforce, construe, or defend any of the terms, conditions or claims or demands covered by this RELEASE AND WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT, either with or without suit, the UNDERSIGNED agrees to pay all attorneys' fees and costs incurred by the indemnified parties.

Property Owner Release (cont.)

3. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND HOLD HARMLESS the indemnified parties and each of them from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about the Farm for any purpose, including, but not limited to, horseback riding, other equine activities, observation, use of facilities or equipment, or participation in any way, whether caused by the negligence of the releasees or otherwise.
4. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE due to the negligence of releasee or otherwise while in, about or upon the premises of the Farm and/or while using the premises for any purpose, including, but not limited to, horseback riding, other equine activities, observation, use of facilities or equipment, or participation in any way.
5. Under Indiana law, Fortune Development, LLC is not liable for an injury to or death of a participant in equine activities resulting from the inherent risks of equine activities. I.C. Section 34-31-5 et. seq.

THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND HOLD HARMLESS AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of Indiana and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THIS RELEASE AND WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT, and further agrees that no oral representations, statements or inducement apart from the foregoing written agreement have been made.

WARNING

Under Indiana Law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

I HAVE READ THIS RELEASE (Rider/Guest 18 years of age or over):

Date ________________ Signature of Guest: ____________________________________
Print Guest's Name: ____

Address: ____
Phone: __________________ Email address: ______________________________________

I HAVE READ THIS RELEASE
(Parent/Guardian if Guest is under 18 years of age or not legally competent)

Date ______________ Signature of Parent/Guardian: ___________________________________
Print Parent/Guardian Name: ____________________________________
Print Name of Participant/Guest: _____________________________________
Address: ____
Phone: __________________ Email address: ____

2021 COVID-19 Acknowledgement of Risk and Acceptance of Services

I, ____ (Participant Name), am aware of the risks of contracting COVID-19 while receiving services from Morning Dove Therapeutic Riding Center, Inc.

I am aware that face-to-face services increase my risk of contracting and passing on the COVID-19 or coronavirus and agree to hold harmless Morning Dove Therapeutic Riding Center, Inc., its employees and all other individuals I may come in contact with while on the grounds or during this interaction and receiving of services.

I agree to and will follow all guidelines for personal hygiene, personal safety and public safety as recommended by Morning Dove Therapeutic Riding Center, Inc. This may include, but is not limited to, waiting in my vehicle during classes and/or social-distancing while on the property; use of hand sanitizer upon request; and/or wearing a protective medical mask while at Morning Dove.

I agree to cancel my services should I have within the previous 24 hours to 2 weeks personally exhibited or have been in contact with someone who has presented with illness including: cough, sneezing, fever, chest congestion or additional signs of potential spread of any virus or bacteria/disease. In addition, I will follow the recommendations of my provider once I have notified them of these risks in regard to my future services during this pandemic.

Morning Dove Therapeutic Riding Center, Inc. will engage in regular cleaning and sanitizing of horse tack, grooming supplies and office, doors, and frequently touched areas in between clients and on a daily basis as recommended by the CDC and our Veterinarian team for the safety of clients, employees, volunteers and horses.

I am signing under my own free will and choice and agree to follow these and hold harmless all individuals associated with or through my services acquired from Morning Dove Therapeutic Riding Center, Inc.

Client Name: ____ Date: _______________

Client Signature: ____

Parent/Guardian Name: ____ Date: ______________

Parent/Guardian Signature: ____

Witness Signature: ____ Date ____________