New Life Equine Therapy Facility

WHERE HEALING BEGINS

REGISTRATION FORM

Please read and fill out completely, initialing pages 1 & 2, signing the bottom of the last page where indicated acknowledging that you have read, understand and agree to all terms contained herein.

EQUINE ASSISTED THERAPY-PRIMARY DIAGNOSIS

Student Name:

Age: DOB: M: F:

Address: City:

State: Zip:

Preferred Phone Number: Email:

Preferred Day(s): M T W TH F S AM PM

Primary Contact Name:

Daytime Phone: Evening Phone:

Email:

Secondary Contact Name:

Daytime Phone: Evening Phone:

Email:

Insurance Name: Policy No.

ALL CO-PAYMENTS ARE DUE AT TIME OF EQUINE ASSISTED SERVICES

Cash and or Check $

Credit Card No. Visa Master

Expiry Date: SSC Code:

I agree to pay all charges as per the terms of my cardholder agreement. Initials

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SAFETY GEAR

I understand that a proper riding helmet and boots are necessary safety equipment for any equine activity and I take full responsibility for providing and for the wearing of such equipment while so engaged, if parent or legal guardian chooses not to provide their child with such safety equipment, by signing this release, parent/legal guardian gives consent and confirms that the uses of such safety equipment is not necessary for your child and therefore you take full responsibility for this decision as the parent or legal guardian.

Full Name:

Signature: