THERAPYWORKS NORTHWEST
*Physical, Occupational & Speech Therapy*
www.therapyworksnw.com • 503-663-0481 • Fax 503-663-0480 • 7927 S.E. Orient Drive, Gresham, OR 97080

# Volunteer Information

**Name**: **Date**:

**Address**:

**Email**:

**Phone**:_____ Text capability? Yes No

Preferred method of communication: _____

**Areas of Interest:**

- ☐ Sidewalker
- ☐ Horse Care
- ☐ Horse Training Assist
- ☐ Barn Cleaning
- ☐ *Please list prior horse experience (if any):*

_____
_____
_____

- ☐ Office
- ☐ Sewing
- ☐ Other:

_____
_____
_____

**Please list general availability and/or other restrictions:**

Mondays_____ Fridays_____ *Other Scheduling Notes*:
Tuesdays_____ Saturdays_____ _____
Wednesdays_____ Sundays_____ _____
Thursdays _____ _____

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# Liability Release

**This release may be used against you in a court of law if you file a lawsuit any released party or person**
*(Please read carefully, fill in all blanks and initial each paragraph before signing)*

I, _____, hereby affirm that I am informed of the inherent hazard of sidewalking, horseback riding, driving, care and other horse related activities. I understand and agree that neither, Therapy Works NW, its principals, or any horse owners, landowners nor any of their respective employees, clients and volunteers (here after referred to as "Released Parties") may be held liable or responsible in any way for any injury, death, or other damages, to me, my family or my property, heirs or assigns that may occur as a result of my participation in this horse-related activity or as a result of the negligence of any party, including the Released Parties, whether active or passive.

___In consideration of being allowed to participate in this activity, I hereby personally assume all risk in connection with said activity, for any harm, injury or damage that may befall me or my property while so engaged, including all risk connected therewith, whether foreseen or unforeseen.

____I further save and hold harmless said activity and Released Parties from any claim or lawsuit by me, my family, estate, heirs or assigns, arising during the activity and or afterwards.

____I further understand that horses may behave in unpredictable and potentially dangerous ways. I expressly assume the risk of injuries resultant from my participation in these activities and I will not hold the above listed individuals or companies responsible for the same.

____I understand that in the unexpected event of medical emergency, the employees or agents of TherapyWorks NW have permission to seek and authorize medical attention and services for the Undersigned.

It is my intention by this instrument to exempt and release any and all Released Parties as defined above, from all liability or responsibility whatsoever for personal injury, property damage, or wrongful death, however cause, including but not limited to the negligence of the Released Parties, whether passive or active. I have fully informed myself or the contents of this liability release and express assumption of risk by reading before I signed it on behalf of myself or my heirs.

Print Name (s):_____

Print Guardian Name (If Minor): _____

Address:_____

Phone:_____

Emergency Contact: _____ Phone: _____

Signature:_____ Date:_____

Signature of Guardian:_____ Date:_____

**Under Oregon Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a Participate in equine activities resulting exclusively from the inherent risk of equine activities Oregon Revised Statute 30.687 to 30.697**

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## OVERVIEW OF PRIVACY POLICIES

TherapyWorks NW policy and federal regulations protect the privacy of our patients' health information. The Health Insurance Portability and Accountability Act (HIPAA) is a set of federal rules that defines what information is protected, sets limits on how that information may be used or shared, and provides patients with certain rights regarding their information. TherapyWorks NW has its own policies that reflect these regulations as well as best ethical standards.

These rules protect information that is collected or maintained, (verbally, in paper, or electronic format) that can be linked back to an individual patient and is related to his or her health , the provision of healthcare services, or the payment for health care services. This includes, but is not limited to, clinical information, billing and financial information, and demographic/scheduling information. **Even the fact that an individual has received care at TherapyWorks NW is protected by TherapyWorks NW policy and federal regulations.**

TherapyWorks policy and HIPAA regulations limit the use or sharing of protected patient information to the following purposes: providing treatment, obtaining payment for services, certain healthcare administrative functions and when required or permitted by law. Any other use or disclosure of protected information requires written authorization from the patient. For all uses or disclosures other than treatment, only the minimum amount of information necessary will be shared on a need to basis. The Notice of Privacy Practices describes to patients how we may use or disclose their health information and patient rights regarding their protected health information.

## CONFIDENTIALITY AGREEMENT FOR VISITORS IN CLINICAL AREAS

As a visitor/volunteer at TherapyWorks NW you are required to conduct yourself in strict conformance to all applicable laws and TherapyWorks NW policies governing confidential information. **Simply by being in the clinic and/or barn areas, you may encounter confidential patient information.** Care is often coordinated in semi-[ublic environments where there is the risk that patient information may be heard or viewedby individuals not directly involved in the patient's care. TherapyWorks NW has policies intended to limit the risks of such incidental disclosures of patient information. You may see or hear information related to TherapyWorks NW patients (such as charts and other paper and electronic records, demographic information, conversations, admission/discharge dates, names of physicians, patient financial information, etc.). **Any patient information you see or hear, either incidentally or by attending observation hours or volunteering, must be kept confidential. By signing below, you are agreeing to abide by TherapyWorks NW's policies regarding confidentiality of patient health information.**

As a condition of and in consideration of, my use, access, and/or disclosure of confidential information,
I, _____, understand and agree to the following:

- I will access, use, and disclose confidential information only as permitted by TherapyWorks NW hosts. This means that I will only access, use, and disclose confidential information that I have been given authorization to access, use and disclose.
- I understand that any fraudulent application, violationof confidentiality or any violation of the above provisions will result in the termination of my privelege to observe and participate in clinical and barn areas and I may be subject to legal liability as well.
- My signature below indicates that I have read, accept, and agree to abide by all of the terms and conditions of this Agreement and agree to be bound by it.

Signature:_____ Date:_____