Bit by Bit
Medical Therapeutic Riding Center
Address: 3141 SW 118 Terrace, Davie, Florida 33330
Office: 754-779-7888 Fax: 954-414-8363 Email: info@bitbybittherapy.org

Welcome to Bit-by-Bit!

Dear New Applicant,

Welcome to Bit-by-Bit! We're excited to have you join our program.

To begin the enrollment process, please call 754-779-7888 and speak with the intake coordinator.

Autopay Option (Preferred Payment Method)

Avoid late fees and streamline your payments by signing up for Autopay.

- Secure auto-debit from your credit card or bank account
- Immediate email receipts
- Cancel anytime

Before Your First Visit:

Please submit the following items via email or fax:

- A copy of your child's insurance card (front and back)
- A physician's prescription/physician's clearance (last page of packet)
- Completed registration packet
- All payments must be arranged before your first session

Barn Address: 3141 SW 118 Terrace, Davie, FL 33330

Directions to the Barn:

From the West (I-595):

Exit at Flamingo RD, head South. Turn Left on SW 26 ST. Turn Right on SW 121 AVE/Peaceful Ridge RD. Turn Left on SW 32nd DR. Left into the cul-de-sac SW 118th TER.

From the East (I-595):

Exit at Hiatus RD, head South. Turn Right on SW 26 ST. Turn Left on SW 121 AVE/Peaceful Ridge RD. Turn Left on SW 32nd DR. Left into the cul-de-sac SW 118th TER.

Bit-By-Bit, Inc. is a 501(c)(3) nonprofit organization.

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Billing Policy and Procedures:

Pre-Payment Policy

- Pre-payment **in full** is required for the entire month, due at the beginning of each month via autopay.
- We offer **standing monthly appointments** only – no partial sessions.

Cancellation Policy

- Make-ups are offered only if you provide more than 24-hour notice.
- If less than 24 hours' notice is given, it is considered a cancellation.
  - A $15 "Late-Cancellation" Fee may be charged. The missed session will be forfeited.
  - Participants with two or more cancellations may be discharged from the program.
- If no notification is provided it is considered a no-show.
  - A $25 "No-Show" Fee may be charged and session will be forfeited.
  - Participants with two or more no-shows may be discharged from the program.
- Weather Cancellations:
  - We operate rain or shine unless you receive a text/call from our staff
  - In some cases, therapy may be performed in the barn or treatment room.

Therapy / Hippotherapy / Equine Assisted Therapies and Activities:

- Medicaid (and related subnetworks) are accepted.
  - An additional "Barn Fee" of $82/month applies for the use of facility and equipment
- Private Physical / Occupational / Speech Therapy Services
  - Not covered by insurance (private insurance is not accepted)
  - Sessions may be paid privately at $90 per half hour.
  - Monthly statements can be provided for self-submission to your insurance.

Therapeutic Recreational / Adaptive Riding Program:

- Not reimbursable by insurance and must qualify
- Physician clearance is required for all participants

Program Type	**Price**	**Description**
Private Lessons	$50.00	30 minutes of private instruction
Group Lessons (2-4 riders)	$50.00 each	45-60 minutes of instruction based on riding level. Activities include riding, tacking, and aftercare.

Veterans Program:

- "Horses For Heroes" – Our Veteran Rehabilitation Program is offered completely free of charge to our disabled veterans

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Barn Rules – Please Keep for Your Records

Arrival & Preparation

- Please arrive at least 10 minutes early for your appointment
- Make sure your child is ready for their session (bathroom needs completed beforehand).

Required Attire

- **All riders must wear appropriate clothing** for equine activities:
  - **Closed-toe shoes with socks are required** – no sandals, flip-flops, crocs, or open-toed shoes.
  - This rule applies to **everyone**, including parents and guardians.
- Wear long pants: jeans or material pants are required.
  - No shorts or capri pants ending above mid-calf (legs may become chafed against saddle)
- Helmets:
  - If you own an approved **equestrian riding helmet**, please bring it.
  - **Bike helmets are not acceptable** as they do not offer adequate protection.
  - Special helmets may be approved by your therapist for specific conditions**.**

Health and Safety

- Be sure to hydrate **before and during** session.
  - **Bring bottled water with you for each visit**.
- Let us know of any behavioral or health concerns before each session begins.
- **Do not feed any horses or animals – all animals may bite or kick**.
- Supervise all children and siblings closely:
  - Our fences are electrified (disabled during sessions but still dangerous if mishandled).
  - No climbing on fences or gates.
  - No photos or videos of children other than your own.

Facility Rules

- **You may not walk around the barn without direct supervision from staff.**
- No smoking
- No pets on premises.
- Sit in the designated parent viewing area.
- Park in designated area. If you have a BBB issued parking permit you can park up front.

Code of Conduct

- You are a guest at Bit-by-Bit. Please be respectful to staff, volunteers, other guests, our animals and property.
- Disruptive behavior (loud, rude, or inappropriate) may result in removal from the facility.
- We aim to maintain a positive and respectful atmosphere.
  - If you have any concerns, please speak to your therapist privately or call us directly.
  - Privacy and courtesy are essential

Always call if you have any questions regarding the above policies. Thank you for helping us provide a safe and supportive experience for everyone.

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Authorization for Emergency Medical Treatment Form

Client Information

- Name:_____
- Date of Birth: ____/_____/_____Phone:_____
- Address: _____City_____State_____Zip_____

Medical Information

- Physician:_____
- Preferred Medical Facility:_____
- Health Insurance Company:_____
- Insurance ID number;_____
- Allergies:_____
- Medications currently taking:_____

Emergency Contact(s)

- Name:_____Relationship:_____Phone:_____
- Name:_____Relationship:_____Phone:_____

Consent for Emergency Medical Treatment

In the event that emergency medical aid or treatment is required due to illness or injury while receiving services or being on the property of Bit-by-Bit, I authorize Bit-by-Bit to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized medical agency.

☐Non-Consent Plan (Not Recommended)

I do **not** give consent for emergency medical treatment in the event of illness or injury during services or while on the property.

Conditions of Non-Consent:

- A parent or guardian **must remain on site** during all equine-assisted activities.
- If I am not on site in violation of Bit-by-Bit policy, I accept full financial responsibility for emergency treatment.
- In such a case, I instruct the following procedure(s) to be taken:
  _____
  _____

Date:____/_____/_____ Consent Signature:_____

☐Recommended Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment deemed “lifesaving” by the physician. This will only be enacted if the emergency contacts above cannot be reached.

Date:____/_____/_____ Consent Signature:_____

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Participant's Application and Health History

Participant Information

- Name: _____Date of Birth: _____/_____/_____ Age: _____
- Height: _____Weight: _____ Gender: ☐M ☐F Phone: _____
- Race/Ethnicity: ☐White ☐Asian ☐African American ☐Hispanic ☐Other_____
- Email Address:_____Employer/School: _____

Referral Details

- Referral Source: _____ Referral Phone: _____
- How did you hear about the program? _____

Health History

- Diagnosis:_____Date of Onset: _____/_____/_____

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication/Verbal/Non Verbal			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Mandatory – Additional Therapy Services

Please complete if your child currently receives therapy services:

☐ **Speech Therapy:** _____ minutes/_____times per week/ Facility: _____

☐ **Physical Therapy:** _____ minutes/_____times per week/ Facility: _____

☐ **Occupational Therapy:** _____ minutes/_____times per week/ Facility: _____

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Medication Information

Please include all prescriptions and over-the-counter medications

Name	Dose	Frequency

Functional Information

Please describe your abilities/difficulties in the following areas. (Include assistance required or equipment needed)

- Physical Function
  (e.g., mobility skills such as transfers, walking, wheelchair use, driving, bus riding)
  _____
  _____
- Psycho/Social Function
  (e.g., work/school, grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)
  _____
  _____
- Activities of Daily Living
  (e.g., self-care skills; dressing, toileting, feeding)
  _____
  _____
- Goals
  (e.g., What would you like to see accomplished? Why are you applying for participation?)
  _____
  _____

Availability

Please list the days you are available. We will do our best to accommodate your schedule. Please note that if we bill under insurance, we cannot bill the same service at two different locations on the same day.

Day	Times available
Monday (additional non-mounted sessions)	10:00 am -6:30 pm
Tuesday (mounted sessions)	2:30 pm -6:30 pm
Wednesday (mounted sessions)	2:30 pm-6:30 pm
Thursday (mounted sessions)	2:30 pm-6:30 pm
Saturday (mounted sessions)	9:00 am-12:30 pm
Sunday (mounted sessions)	9:00 am-12:30 pm

Photo Release

☒ I DO (suggested default)
☐ I DO NOT (you may check)
I consent to and authorize the use and reproduction by Bit-by-Bit, Inc. of any and all photographs and audio/visual materials taken of me for promotional material, educational activities, exhibitions, or any other use that benefits the program.

Date:____/_____/_____ Consent Signature:_____

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Behavior Policy

Purpose:

This Behavior Policy is designed to promote a safe and respectful environment for the well-being of all clients, families, staff, volunteers and visitors during mounted and unmounted sessions. A calm, respectful environment is essential for effective therapy and safety of all participants-both human and equine.

Expectations:

- Show respect towards all staff, volunteers, property and horses.
  - Use kind voices and gentle hands around others and horses.
  - Avoid yelling, physical aggression, or threatening actions.
- Follow Safety Guidelines
  - Adhere to all program guidelines, safety procedures, and directions given by staff or supervisors.
  - Use equipment and materials safely and as directed.

Unsafe or Disruptive Behavior:

- Aggression (hitting, biting, kicking, etc.) towards people and animals
- Destruction of property or equipment
- Refusal to follow safety instructions
- Verbal threats or inappropriate language
- Purposeful teasing or harming animals

Response to Behavior:

1. Verbal redirection and positive reinforcement
2. Temporary removal from the activity or space by providing breaks or redirection
3. Parent/guardian consultation
4. Behavior support plan or modifications to session structure
5. In rare cases, discharge of services and/or referral to higher level of care

Our approach:

Our team uses a calm, supportive and individualized approach. We believe all behavior has meaning and work with clients to build skills in regulation, trust, and communication. If necessary, bear hugs or deep pressure activities will be used to help calm the child. No restraints are used on premises. However, if a client with a history of aggressive behaviors to others a parent/guardian must stay on premises. If a child's behavior is deemed unmanageable, lasts more than 10 minutes or is a threat to others and/or self during therapy, the sessions will be discontinued, and future sessions will be authorized only after consultation with parent/guardian.

Commitment to Care and Safety:

By working together and following this policy, we ensure each client's experience in therapy is safe, meaningful, and goal focused. All clients, parents, and staff are expected to uphold these guidelines to ensure everyone's safety and therapeutic success.

Date:____/_____/_____ Consent Signature:_____

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Statement of Patient Rights and Responsibilities

As an Out-Patient Client, You Have the Right To:

1. Receive information about your rights and responsibilities regarding therapy services.
2. Receive a timely response from the therapy company regarding your request for therapy.
3. Be informed of the therapy company's policies, procedures, and charges for services.
4. Choose your therapy providers.
5. Receive appropriate and professional quality services without discrimination based on race, creed, color, religion, sex, national origin, sexual preference, handicap, or age.
6. Be treated with courtesy and respect by all staff.
7. Be free from physical and mental abuse or neglect.
8. Be informed of the name and title of everyone involved in your care.
9. Receive complete and understandable information about your condition, treatment, prognosis, and alternatives.
10. Give informed consent before any treatment begins.
11. Have a care plan that is developed to meet your individual needs.
12. Actively participate in the development of your care plan.
13. Be given an assessment and plan for your individualized care.
14. Receive data privacy and confidentiality.
15. Refuse or discontinue treatment (with prior notice and physician's order).
16. Be informed about the progress of transferring or discontinuing care.
17. Express grievances or suggest changes in therapy without fear or reprisal.
18. Refuse treatment within legal boundaries.
19. Be informed about the consequences of refusing treatment.

As an Out-Patient Client, You Have the Responsibility To:

1. Provide complete and accurate health information (past illnesses, hospitalizations, medications, allergies, etc.).
2. Assist in creating and maintaining a safe therapy environment.
3. Notify the therapy company if you are unable to attend a scheduled visit.
4. Participate in developing and updating your health care plan.
5. Follow the agrees-upon care plan.
6. Ask questions if you do not understand information given to you.
7. Communicate any concerns or problems to the therapist or company.

STATE OF FLORIDA – Department of Health and Rehabilitative Services

To report abuse, neglect, or exploitation, please call toll-free 1-800-96-ABUSE (24 hours a day, 7 days a week).

Acknowledgment

I understand my Bill of Rights and have received a copy of it.

Date:____/_____/_____ Consent Signature:_____

Date:____/_____/_____ Signature of Therapist:_____

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Consent / Release / Bill of Rights

Patient Name: _____

Consent to Receive Service

I hereby authorize Bit-by-Bit, Inc. to render appropriate health care to the patient named above. I recognize and agree that I have the right to refuse treatment or terminate services by notifying Bit-by-Bit, Inc. in writing. Bit-by-Bit, Inc. may terminate services by notifying me of termination and the reason.

Authorization for Emergency Medical Services

At any such time that Bit-by-Bit, Inc. is on assignment, and in the event of any medical emergency, I authorize Bit-by-Bit, Inc. to provide or obtain such medical treatment as deemed advisable under the circumstances. I agree to assume sole responsibility for all charges for such treatment.

Release of Medical Records

I herby consent and I request that copies, if necessary, of my prior medical records be delivered to Bit-by-Bit, Inc. to establish or continuing my care and treatment plan.

I also hereby authorize Bit-by-Bit, Inc. to release copies of my medical records-or reports or such portions or summaries thereof as may be relevant, to other health care providers, facilities, or regulatory/accrediting bodies for the purpose of continuing and coordinating my plan of treatment and for quality assurance, survey and accreditation purposes.

Medicaid / Payment Authorization

As a Medicaid patient, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made to Bit-by-Bit, Inc. on my behalf. I also certify that I will provide all necessary paperwork/ documentation/notifications to Bit-by-Bit immediately if there is a change in my Medicaid status. I also certify that I will provide Bit-by-Bit, Inc with all necessary paperwork so that this provider can effectively bill Medicaid and/or my primary insurance company in a timely manner. I certify that failure to do so on my part, I will personally financially accountable and liable for private pay therapy rates for the services rendered to me and/or my family member/child.

Statement of Patient Rights and Responsibilities

I certify that I have read, received a copy of, and understand the Statement of Patient Right and Responsibilities, which has been explained to me verbally by a Bit-by-Bit, Inc. representative.
NOTE: This form must be signed by the patient of Bit-by-Bit, Inc unless the patient is a minor, legally incompetent, or physically incapable of signing,
I have read and fully understand the content of this multi-purpose admission form and hereby agree to and authorize the foregoing provisions.
As used in this document, the terms," I", "me", and "my" refer to and include, in addition to the undersigned, the patient named above and others for whom the undersigned has assumed legal responsibility in engaging Bit-by-Bit, Inc. to provide services to the patient.

Patient Signature: _____Witness_____

Authorized Representative of Patient: _____

Date: _____/_____/_____ Relationship to Patient: _____

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2026

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Equine Professional Release

KNOW ALL MEN by these PRESENTS, that

_____ (*Write participant name*) who resides at

_____(*write address*) (hereinafter referred to as "participant), desires to engage in and hereby does engage in the services of Bit-By-Bit, Inc., and all of its, EMPLOYEES, Trainers, therapists, instructors, volunteers, board of directors, independent contractors, animals, and others (hereinafter referred to as "EQUINE PROFESSIONAL"), LOCATED AT **:** 3141 SW 118th Terrace, Davie, Florida 33330 to instruct/provide services for the participant in recreational riding, riding lessons, therapeutic riding / adaptive riding lessons, camp, hippotherapy, physical, occupational, and/or speech therapy, medical therapy related services, equine care and management, equine assisted therapy or activities, horse shows, trail riding, Pony Scouts, horse training, parades, workshops, scouting programs, parties, fundraisers , educational classes or workshops, public events, any and all independent contractor and/or volunteer activities, experiences, and duties, transportation and any other farm sponsored, charitable activity or equine activity.

FOR AND IN CONSIDERATION OF THE ABOVE SERVICES, Participant hereby does and forever and finally release, remise, acquit, satisfy and forever discharge Bit-By-Bit, Inc., and all of its, actions, cause and causes of actions, debts, dues, suit, sums of money, bonds, billings, contracts, controversies, agreement, promises, damages, variances, judgments, executions, claims, and demands whatsoever, including, but not limited to attorney's fees and disbursements, in law or in equity, which may arise or might in the future arise or hereinafter may arise for or against the Equine Professional for the services as stated above. This document is meant to be a **full and complete release from all and any liability** and release against any claims based on negligence, actions or inactions of the above named parties, and any claim that may arise from instructing the participant on how to properly ride, manage and care for horses and other animals, and all program activities, medical treatments, therapeutic activities, and/or animal related activities. I hereby release the EQUINE PROFESSIONAL(S) from any and all liability from any injury or damage that may occur from participation in the inherently risky equine activities that may or may not be the result of either simple and gross negligence, and by signing this agreement acknowledge the possible risks and dangers that could result from participation in equine activities, whether caused by the equine sponsor's negligence or the inherent risks of equine activities. This release is given freely and voluntarily by the participant and is meant to remain in existence throughout the duration of any instruction, medical treatment, charitable, independent contractor, volunteer, or equine related activity. **Photo release:** I also consent to **or** (check *only if applies*- O do not consent to) and authorize the use and reproduction by Bit-By-Bit, Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

WARNING:

Under Florida law, an equine activity sponsor or 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.

Dated this _____ day of _____, _____

Participant Signature _____ Phone _____

Legal Guardian Signature (required if < 18 years old)_____

Emergency Phone Number:_____

Complete Address _____

****Email Address****: _____

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For Physician:

Please attach this page to the completed Medical History and Physician's Statement Form.

Dear Health Care Provider,

Your patient, _____(Participant's Name), is interested in participating in supervised equine-assisted activities at our center.

To ensure the safety and well-being of all participants, we kindly request that you complete or update the attached Medical History and Physician's Statement Form. Please review the conditions listed below, as they may indicate **precautions or contraindications** for equine-assisted activities. When completing the form, note the presence and severity of any applicable conditions.

Relevant Conditions to Consider

Medical/Psychological

- Allergies
- Animal Abuse
- Cardiac Conditions
- Physical, Sexual, or Emotional Abuse
- Blood Pressure Control
- Danger to Self or Others
- Exacerbation of Medical Conditions (e.g., RA, MS)
- Fire Setting
- Hemophilia
- Medical Instability
- Migraines
- Neurological Conditions
- Peripheral Vascular Disease (PVD)
- Respiratory Compromise
- Seizures
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorders

Other Considerations

- Age (under 4 years)
- Indwelling Catheters/ Medical Equipment
- Medications (e.g., Photosensitivity)
- Poor Endurance
- Skin Breakdown
- Recent Surgeries
- Spina Bifida/Chiari ! Malformation/ Tethered Cord/ Hydromyelia

Orthopedic

- Atlantoaxial Instability
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossification/ Myositis Ossificans
- Joint Subluxation/ Dislocation
- Osteoporosis
- Pathological Fractures
- Spinal Joint Fusion/ Fixation
- Spinal Joint Instability/ Abnormalities

Thank you for your time and cooperation. Should you have any questions regarding this patient's participation in equine-assisted activities, please do not hesitate to contact us at the number provided above.

Sincerely,
Denise Panariello
President
Bit-by-Bit, Inc.

2026*

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Office: (754) 779-7888 **Fax: (954) 414-8363** **Email:** *Info@BitByBitTherapy.org*

Participant's Medical History & Physician's Statement (for DOCTOR!)

Participant: _____ DOB: ____/_____/____ Height _____ Weight _____
Address: _____
Phone:(_____) _____ Client Email address: _____
Diagnosis: _____**ICD-10 Code**: _____ Date of onset _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: ☐Y ☐ N Date of Last Seizure _____
Shunt Present? ☐Y ☐ N Date of last revision _____
Special Precautions/Needs: _____
Independent Ambulation ☐ Y ☐ N Braces/ Assistive Devices ☐ Y ☐ N Wheelchair ☐ Y ☐ N
For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ results + --
Neurologic Symptoms of AtlantoAxial Instability: _____
Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	*Comments*
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional			
Pain			
Other			

Doctor Prescription:

(Required for Medical Therapy Services)

Date: _____ / _____ / _____

Patient: _____
ICD-10 Code: _____

RX: PLEASE CHECK SERVICE(S) PRESCRIBED:

- ☐ **Physical therapy**
- ☐ **Occupational therapy**
- ☐ **Speech therapy**

Evaluation and treatment.

Signature:

_____

(Physician handwritten signature only)

MANDATORY: Physician Medicaid Provider ID # :

_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

Doctor Name Printed:_____**MD DO NP Other** _____
Signature:_____ **Date:** _____ **License/UPIN Number**_____
Office Phone: (_____)_____ **Office Fax** :_(_____)_____
Office Address: _____