APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

APPLICANT INFORMATION

Applicant Name: _____ Date: _____

Parent or Legal Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone #: (H): _____ (C): _____ (W): _____

Height: _____ Weight: _____ Date of Birth: _____

Email: _____

Gender (check one): □ Male □ Female □ Other Preference: _____

Preferred pronouns: _____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____(APPLICANT NAME), hereby authorize and request that

_____

(Mental Health Professional or Mental Health Facility) may release to EQUI-KIDS Therapeutic Riding Program the following information (please check the allowable information):

Check Box	Description	Check Box	Description
	Admission for Treatment		Diagnosis
	Psychiatric Evaluation		Psychological Testing Results
	Treatment Progress Notes		Discharge Summary
	Physician Orders		Other:

The purpose of this disclosure is for the development of an Equine-Facilitated Psychotherapeutic Plan and program. I understand that this authorization will remain in effect for 1 year. This information will not be forwarded to any other provider or agent. This information will be released in the following format (Check All That Apply):

Check Box	Method of Release
	Verbal per telephone
	Electronic
	Snail Mail
	Hand Carried

Applicant Signature: _____ Date: _____

Parent or Legal Guardian Signature if under 18: _____ Date: _____

Referring Mental Health Professional _____ Date: _____

Address of Mental Health Professional: _____

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

MEDICAL HISTORY

Applicant Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Height: _____ Weight: _____ Date of Birth: _____

Primary Diagnosis: _____ ICD10 Code: _____

Onset (please check one): ☐ Birth ☐ Childhood ☐ Adolescence ☐Adult

Secondary: _____ ICD 10Code: _____

Tertiary: _____ ICD 10Code: _____

*****Please answer the following questions for participants with Down Syndrome*****

Atlantodens Interval X-Ray Results: ☐ POSITIVE ☐ NEGATIVE X-Ray Date: _____

Neurological Symptoms of Atlantoaxial Instability? ☐ YES ☐ NO

Please provide a copy of negative X-Ray Results when returning application to EQUI-KIDS

PLEASE LIST ALL CURRENT MEDICATIONS (Additional medications can be listed on separate paper)

1. _____ Taken For _____
2. _____ Taken For _____
3. _____ Taken For _____

Ambulatory: ☐ YES ☐ NO Uses: ☐ Crutches ☐ Braces ☐ Cane ☐ Walker ☐ Wheelchair

Special precautions needed with this applicant: _____

Please answer the following medical questions:

Question	Answer
Does the applicant have seizures?	☐ YES ☐ NO
• Are seizures controlled?	☐ YES ☐ NO
• Type of Seizure	
• Date of Last Seizure	
Does the applicant have any indwelling medical devices?	☐ YES ☐ NO
• Please list devices if applicable	

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Please indicate if any of the conditions below are present and to what degree.

Check if applies	Condition	Note
	Aggressive behavior	
	Allergies	
	Appetite changes	
	Animal abuse	
	Anxiety	
	Atlantoaxial instability	
	Balance	
	Blood pressure control	
	Body temperature deregulation	
	Cancer	
	Cardiac	
	Chiari I or II malformation	
	Circulatory issues	
	Cognitive impairment	
	Coxa arthrosis	
	Cranial deficits	
	Difficulty sleeping	
	Depressed mood	
	Eating disorder	
	Emotional/psychological	
	Excessive sleep	
	Fatigue / low energy	
	Fear	
	Fire setting	
	Hallucinations / paranoia	
	Hearing Impaired / Sensitivity	
	Hemophilia	
	History of or current suicidal ideation	
	History of or current homicidal ideation	
	History of suicide attempts	
	History of past psychiatric medications	
	Hopelessness	
	Hydrocephalus	
	Immunity	
	Internal spinal stabilization device/s	

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Check if applies	Condition	Note
	Isolation from others	
	Joint replacement	
	Joint subluxation/dislocation	
	Learning disability	
	Low motivation	
	Low self-esteem	
	Migraines	
	Muscular issues	
	Neurological condition	
	Orthopedic condition	
	Ossifications-Heterotopic	
	Ossificans-Myositis	
	Panic	
	Paralysis	
	Paralysis due to spinal cord injury	
	Pathological fractures	
	Peripheral vascular disease	
	Physical/Sexual/Emotional abuse history	
	Prescribed psychiatric medications	
	Pulmonary	
	Respiratory impairment	
	Self-harm	
	Shunt/Shunt Revision	
	Skin break down	
	Speech impairment	
	Spina bifida	
	Spinal joint fusion / fixation	
	Spinal joint instability/abnormality	
	Stroke	
	Substance abuse	
	Tactile sensation impairment	
	Tearful or crying spells	
	Tethered cord	
	Thought control disorder	
	Trouble concentrating	
	Visual impairment	

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Please list any other medical conditions we should to know about:_____

_____

_____

_____

I certify the above information has been completed to the best of my knowledge. I understand that EQUI-KIDS will weigh this medical information against the existing precautions and contraindications.

_____ _____

Printed Name of Participant, Volunteer, Guest, or Staff Date

_____

Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Release, Waiver & Indemnity Agreement

I, the undersigned or parent or legal guardian of the undersigned (either as a "Participant, Volunteer, or Staff''), desiring to utilize the premises known as the EQUI-KIDS Therapeutic Riding Program at 2626 Heritage Park Drive, Virginia Beach, VA 23456 known as "the Premises") and the facilities either owned or controlled by EQUI-KIDS Therapeutic Riding Program, and to participate in programs offered by EQUI-KIDS Therapeutic Riding Program (the Programs), do hereby affirm that as a Participant, Volunteer, or Staff is voluntarily entering upon the Premises to participate in the Programs, and I, as the undersigned or parent or legal guardian of the undersigned, do hereby willingly enter into this Release, Waiver and Indemnity Agreement. I recognize that, under Virginia law, an equine activity sponsor or professional is not liable for an injury to or the death of a Participant, Volunteer, or Staff in equine activities resulting exclusively from the inherent risks of equine activities. I fully understand that the activity of mounting, riding, boarding, feeding, or even being near a horse, involves numerous dangers and risks of injury to the Participant, Volunteer, or Staff and I completely release the owner of the Premises, and EQUI-KIDS and its officers, directors, volunteers, employees, or its agents from any and all liability for any and all injuries from the Participant's, Volunteer's, or Staff's engagement in the Programs offered by EQUI-KIDS Therapeutic Riding Program. I expressly agree that this Release, Waiver, and Indemnity Agreement shall be governed and construed as being sufficient to satisfy the assumption of risk and waiver requirements necessary to relieve equine activity sponsors and equine professionals from liability under the Virginia Equine Activity Liability Act, Section 3.1-796.130, *et.seq*. of the Code of Virginia (the "Act"), and the owners of the Premises, EQUI-KIDS Therapeutic Riding Program and its officers, directors, volunteers, employees, and agents are covered as equine activity sponsors and/or equine professionals by the provisions of the Act. This Release, Waiver, and Indemnity Agreement shall be governed and construed by the laws of the Commonwealth of Virginia, regardless of where any injury or loss shall occur. In the event that any portion of this Release, Waiver, and Indemnity Agreement shall be declared unenforceable, such declaration shall not affect the remaining terms of this document, which shall survive intact. I hereby give my permission to participate in the Programs offered by EQUI-KIDS Therapeutic Riding Program as a Participant, Volunteer, or Staff, and in consideration, agree individually and as applicable, on behalf of my child or ward, to the terms of the above agreement and release of liability.

Printed Name of Participant, Volunteer, Guest, or Staff

Date

Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Confidentiality Policy

Maintaining the confidentiality of our participants' medical and sensitive information is of utmost importance to the staff at EQUI-KIDS Therapeutic Riding Program. Participants and their families have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. EQUI-KIDS Therapeutic Riding Program staff and volunteers will preserve this right of confidentiality for all individuals in its program. EQUI-KIDS Therapeutic Riding Program staff, volunteers, and workshop participants will keep confidential all medical, social, referral, personal, and financial information regarding a person and his/her family. All participants, their families, volunteers, employees, and guests have a right to confidentiality. Equine Facilitated Psychotherapy is a medical service and federal confidentiality regulations apply for participants in these services. Anyone who works, volunteers for, participates in, or provides services to EQUI-KIDS Therapeutic Riding Program is bound by this policy. This includes, but is not limited to, full and part time staff, independent contractors, temporary employees, volunteers, and guests. In effect, this policy applies to anyone connected to EQUI-KIDS Therapeutic Riding Program who could obtain medical/sensitive information accidentally or purposely. Confidentiality includes photographic/video imaging. I affirm that I understand this policy in its entirety and I agree to comply.

_____ _____

Printed Name of Participant, Volunteer, or Staff Member Date

_____

Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)

Media Consent

Please select an option below to advise us of your media consent preferences.

☐ **I DO CONSENT** for valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM**, permission to take or have taken still and/or moving photographs and films, including, but not limited to, television, pictures of myself or my (son/daughter/ward) and consents and authorizes the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM**, and its advertising agencies, news media and any other persons interested in the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM**, and its work, to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional, clinical and/or research material and books. With respect to the foregoing matters, no inducements or promises have been made to me /us to secure our/my signature(s) to this release other than the intention of the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM**, to use or cause to be used such photographs, film and pictures for the primary purpose of promoting and aiding the program and its mission.

☐ **I DO NOT CONSENT** for reasons that I am not obligated to disclose, for photographs, either still or moving, or any television or news media, to be taken of myself, or my son/daughter/ward, by the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM** or any persons working on behalf of said program. I understand that a **RED MARK** will be placed on the record kept in the administrative offices of the program, which will designate that photographs are not allowed of myself or said person.

_____ _____

Printed Name of Participant, Volunteer, or Staff Member Date

_____

Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Medical Treatment Authorization

Applicant:_____ DOB:_____

Address:_____

City: _____ State:_____ Zip:_____

Phone #'s: (H):_____ (C):_____ (W):_____

In the event of an emergency, contact:

Name:_____ Phone:_____

Relationship:_____

Physician's Name:_____ Physician Phone:_____

Medical Facility:_____ Facility Phone:_____

Health Insurance Company:_____ Policy #:_____

In an effort to provide the best care possible please indicate below:

I am allergic to the following medications:_____

I have the following ongoing medical conditions (diabetes, seizures, etc):_____

CHECK ONE OF THE OPTIONS BELOW TO INDICATE CONSENT OR NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

CONSENT FOR EMERGENCY MEDICAL TREATMENT

□ **I DO** consent for emergency medical treatment in the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with EQUI-KIDS Therapeutic Riding Program . I authorize EQUI-KIDS and/or its representatives to: 1) Obtain medical treatment and/or transportation if needed and 2) Release records upon request to the authorized agency or its representative involved in the medical emergency treatment.

NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

□ **I DO NOT** give my consent for emergency medical treatment in the case of illness or injury while on the premises of or in connection with EQUI-KIDS Therapeutic Riding Program In the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with EQUI-KIDS. I wish the following procedure to take place (***LIST PROCEDURE ON LINE):*** _____

Note: EQUI-KIDS is unable to guarantee that emergency medical treatment will be withheld

_____ _____

Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18) Date

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

COVID Policies and Requirements

Face-to-face services and experiences increase the risk of contracting and passing on the Covid-19/ Coronavirus/Infectious Diseases. Interactions include, but are not limited to; the receiving of services, providing services, attending an event, or volunteering within the Center. I am aware of the options that may be available for remote services including telephonic and video telehealth, as allowed by insurances and State Licensing Board recommendations, during this Pandemic outbreak or other infectious diseases outbreak.

I agree and will follow all guidelines for personal hygiene, personal safety, and public safety as recommended by the EQUI-KIDS Therapeutic Riding Program; as well as my individual provider/practitioner. This may include, but is not limited to, waiting in my vehicle and/or home until I am asked to enter the building/farm; maintaining social distance; washing my hands prior to and following each session or activity; use of hand sanitizer upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective medical mask and/or gloves.

I agree to stay home and/or cancel my services should I have personally exhibited or have been in contact with someone who has presented with illness within the previous 24 hours to 2 weeks. Symptoms including; cough, sneezing, fever, chest congestion, or additional signs of the potential spread of any virus or bacterial 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 or attendance during this pandemic or any infectious diseases outbreak.

EQUI-KIDS Therapeutic Riding Program will engage in regular cleaning and sanitizing of the facility and frequently touched areas such as offices, doors and door handles, countertops, chairs, and tables as recommended by the CDC for the safety of clients, employees, volunteers, and horses. Equipment used for participant services such as horse tack, grooming supplies, and frequently touched areas in-between clients will be cleaned between clients as recommended by the CDC for the safety of clients, employees, volunteers, and horses.

I affirm that I understand this policy in its entirety and I agree to comply.

_____ _____

Printed Name of Participant, Volunteer, or Staff Member Date

_____

Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

COVID-19 Assumption of Risk and Waiver of Liability

Coronavirus/COVID-19 Warning and Disclaimer

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person during close contact. Participating in or observing activities at EQUI-KIDS Therapeutic Riding Program (the "Center") could increase your risk of contracting COVID-19, and EQUI-KIDS cannot guarantee that you will not become infected with COVID-19.

Acknowledgment of Risk

I, the undersigned, for myself and, if applicable, as parent/guardian on behalf of the minor named below, hereby acknowledge and agree that in consideration for the undersigned participating in or observing activities at the Center: (1) the undersigned is assuming the risks related to COVID-19 inherent to gathering with others and using common facilities and hereby waives the undersigned's rights to claim liability of EQUI-KIDS or others resulting from the assumption of such risks; and (2) EQUI-KIDS is not responsible for sickness or for loss of any kind as a result of COVID-19. I further understand that certain activities at the Center will require additional safety precautions and equipment due to COVID-19, and that, due to physical safety concerns and sudden emergent conditions, certain activities may not permit social distancing of six feet per person at all times.

EQUI-KIDS has taken certain steps to implement recommended guidance and protocols issued by the Centers for Disease Control and Prevention and the Virginia Department of Health for slowing the transmission of COVID-19. The undersigned acknowledges receipt of EQUI-KIDS' current policies and requirements for participation in or observation of activities at the Center in response to such guidance and protocols ("EQUI-KIDS' COVID-19 policies and requirements"). The undersigned acknowledges and agrees that EQUI-KIDS may revise its policies and requirements at any time based on updated recommended guidance and protocols issued by the public health agencies. **The undersigned agrees to comply at all times with EQUI-KIDS' COVID-19 policies and requirements.**

By signing this agreement, **I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 while at the Center and that such exposure or infection may result in personal injury, illness, permanent disability, and/or death**. I understand that the risk of becoming exposed or infected by COVID-19 at the Center may result from the actions, omissions, or negligence of myself or of others, including EQUI-KIDS. I hereby forever release, waive, discharge, and hold harmless, and agree not to sue or assert any claim against, EQUI-KIDS (including its directors, staff, employees, volunteers, and agents) for any loss or damages arising from such exposure or infection. I understand that by signing this document, all liability of EQUI-KIDS (including its directors, staff, employees, volunteers, and agents) to myself for any such loss or damages will be forever extinguished.

I, the undersigned, have read, understand and accept the terms of this Assumption of Risk and Waiver of Liability form. I further acknowledge that no oral representations have been made to me as an inducement to sign this form.

Printed Name of Participant, Volunteer, Guest, or Staff _____ Date _____

Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18) _____

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

HIPPA RELEASE OF INFORMATION

_____

Name of Client

_____

Parent or Legal Guardian (if client is under the age of 18)

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for EQUI-KIDS Therapeutic Riding Program to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give EQUI-KIDS permission to:

Check Box as appropriate

□ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

□ Disclose my complete health record except for the following information

- □ Mental health records
- □ Communicable diseases including, but not limited to, HIV and AIDS
- □ Alcohol/drug abuse treatment records
- □ Genetic information
- □ Other (Specify)

  _____
  _____
  _____
  _____

Form of Disclosure:

- □ Electronic copy or access via a web-based portal
- □ Hard copy
- □ Over the phone

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

Phone Number:_____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Check Box as appropriate

- ☐ From _____ to _____ Or
- ☐ All past, present, and future periods Or
- ☐ The date of the signature in section VI until the following event:

  _____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

EQUI-KIDS
Attn: Kathy Chitwood, Program Director
2626 Heritage Park Drive, Virginia Beach, VA 23456

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Section VI – Signature

_____

Printed Name of Client/Parent or Legal Guardian

_____

Signature of Client/Parent or Legal Guardian

_____

Date

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Date: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

NOTICE OF PRIVACY PRACTICES

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The **Health Insurance Portability and Accountability Act of 1996 "HIPAA"** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your protected health information and how we may use and disclose your health information.

We may use and disclose your protected health information (PHI) only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: if we have reason to believe that a child has been subjected to abuse or neglect, we must report this belief to the appropriate authorities.
- Adult and Domestic Abuse: we may disclose protected health information regarding you if we reasonably believe that you are a victim of abuse, neglect, self-neglect or exploitation.
- Health Oversight Activities: if we receive a subpoena from the Virginia Board of Social Work Examiners because they are investigating our practice, we must disclose any PHI requested by the Board.
- Judicial and Administrative Proceedings: if you are involved in a court proceedings and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. You will be informed in advance if this is the case.
- IF you are under 18 years of age, Virginia law allows your parents or guardians to request information and/or records related to our treatment.
- Serious Threat to Health and Safety. If you communicate to us specific threat of imminent harm against another individual or if we believe that there is a clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm.

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

NOTICE OF PRIVACY PRACTICES CONTINUED

- If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to EQUI-KIDS, 2626 Heritage Park Drive, Virginia Beach, VA 23456.

- The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protective health information. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request we will discuss with you the details of the request and denial process for PHI
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.

If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact EQUI-KIDS at 757-721-7350.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above provides you with the appropriate address upon request.

I acknowledge the receipt of this Notice of Privacy Practices.

Printed Name:_____ Date:_____

Signature (Parent/Guardian if under 18 years of age):_____

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Documentation of Client's Informed Consent for Evaluation/Treatment

Equine Assisted Psychotherapy is an experiential form of treatment that involves participating in activities with horses. It is a team approach that includes the client, horse, psychotherapist and sometimes a horse specialist. Activities are designed to promote emotional growth by recreating life's struggles and encouraging clients to find new solutions to resolve these struggles. Psychotherapy involves a commitment to work toward change and to be actively involved in treatment. This may trigger the emergence of strong feelings and thoughts. Emotional and physical safety is ongoing treatment goals that will continually be assessed during Equine Assisted Psychotherapy. While verbal expression of intense feelings are appropriate in counseling, acting out feelings in a violent or destructive manner is not and may result in termination of treatment or referral to a more appropriate therapeutic setting.

Because equine assisted psychotherapy is conducted in an open setting (in a barn, pasture or arena); maintaining confidentiality poses certain challenges. At times there may be other staff or clients at the facility during your session which may compromise your privacy. We will make every effort to protect your privacy and there will always be a designated space for privacy when requested. However, there may be occasions, which are mandated by law as described in the HIPAA Notice of Privacy Practice where we will be required to disclose personal information.

Therapy involves a large commitment of time, money, and energy. You are entitled to and will receive non-coercive service that protects your right to self-determination. You will be responsible for the payment of service at the time of each appointment. If an appointment is missed and not canceled or rescheduled 24 hours prior to the appointment time, you will be responsible for payment. If EQUI-KIDS is not affiliated with your insurance network, we will be happy to provide you with whatever paper work is necessary to facilitate reimbursement from your insurance company. Please contact them as soon as we have met to obtain authorization and determine whether they require a treatment plan, copy of paid invoice, etc.

By signing below, I agree to begin treatment and accept responsibility for payment for services provided. I have read about the potential limits of confidentiality as described on the sheet entitled NOTICE OF PRIVACY PRACTICES. I have also read and understand the policies described on the CLIENT'S INFORMED CONSENT FORM. I accept these conditions for participating in treatment and I understand that I can discuss any concerns with my therapist at any time.

EQUI-KIDS looks forward to working with you and we will make every effort to provide quality service. We welcome your questions, suggestions and inquiries.

Your signature below indicates; 1) that you have read the information in this document; 2) that I have ensured your understanding of the contents; 3) that you give consent voluntarily; and 4) that you agree to abide by it terms during our professional relationship.

Printed Name:_____ Date:_____

Signature (Applicant/Guardian if under 18 years of age):_____

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Mental Health Financial Policies

- EQUI-KIDS does not bill insurance companies for Mental Health services. Payment is due at the time of service in the form of cash, check, or charge.

- **We require a 24 hour cancellation notice or a $50.00 missed appointment fee will apply**.

- Fees for Mental Health are

    - $200.00 for the initial assessment (individual therapy)
    - $100.00 per hour of service (individual therapy)
    - $400 per participant for 2022 Summer Group (4-week session)

- Payment for Mental Health services are due in full at the time of service.

- There is a $50 returned check fee for any check returned by our bank for insufficient funds.

I have read and understand the financial policies: _____

Signature Date

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

Mental Health Payment & Registration Agreement

Applicant Name:_____

Parent/Guardian Name(s):_____

Address:_____

City/State/Zip:_____

Home #:_____ Cell #:_____ Work #:_____

Email #1:_____ Email #2:_____

Payment for Mental Health services is due at the time of service.

Please make a payment selection:

I/We choose to pay in the following way:

☐ By check

☐ By Credit Card (Please complete the information below)

☐ **VISA** ☐ **MC** ☐ **AMEX** ☐ **DISCOVER** **Card Number:**_____

Name on Card: _____

Expiration:_____ **Security Code:**_____ **Billing Zip Code:**_____

I/we hereby authorize EQUI-KIDS to charge the payments that correspond with the payment plan selected for each session for which the participant is enrolled. This agreement is valid ONLY for mental health services. Fees are due at the time of service.

Authorized Signature: _____ Date: _____