Registration

Client Name _____

Address _____

City _____ State _____ Zip_____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone # _____ Message OK? Yes ___ No ____

Email:_____ Email OK? Yes___ No____

Address _____

Date of Birth _____

Client Marital Status _____ Gender [ ] Male [ ] Female

Employer or School _____

Client Employment Status _____

Referred by: Name:_____

Agency:_____

_____ _____

Client's Name **Date**

_____ _____

Client's Signature **Date**

_____ _____

Witness Signature **Date**

Referral Form

The Horsepower Equine Assisted Learning (HEAL) Foundation

Client Name:_____ Age:_____ D.O.B:_____ _____ M / F

Address:_____ City & State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Message OK? Y / N

Caller Name:_____ Phone#_____Email: _____Relationship to Client:_____

Referring Organization/Contact Person: _____ Phone: _____ Email: _____

Reasons seeking therapy: _____

Previous Treatment?_____Provider: _____

_____

Existing Diagnoses? _____

Psychiatric Hospitalization in past year?_____

Legal Involvement:_____ On probation? Y / N

Medications: _____

Prescribed by:_____ Current Therapist:_____

Medical Issues we should know about: _____

Who will provide transportation? _____

For Office Use Only

If Phone Screening: Answered by:_____ Date:_____

Client Contacted for Intake by:_____ Date:_____

If Outside Referral: Fax Received by:_____ Date:_____

Client Contacted for Intake by:_____ Date:_____

Please Mark Funding: [ ] Self-Pay/Private Ins. (payment due at session) [ ] Medicaid [ ] Grant [ ] Scholarship Fund (waiting list)

Client Rights and Responsibilities

The Horsepower Equine Assisted Learning (HEAL) Foundation

Client Rights

- To receive considerate and respectful services.
- To receive services which demonstrate sensitivity to and respect for diverse cultural backgrounds.
- To receive services without regard to ethnicity, sex, age, handicapping condition, national origin, sexual orientation or economic status.
- To receive current and complete information concerning his/her diagnosis, treatment, and prognosis in terms he/she can understand from the members of the professional staff assigned to his/her case.
- To know by name, specialty, and qualifications the members of staff assigned to his/her case.
- To have the consideration of privacy and individuality as it relates to social, religious and psychological wellbeing.
- To have the respectfulness and privacy as it relates to his/her individual care program. Case discussion, consultation, examination, and treatment are confidential and are conducted discreetly.
- To obtain information on the relationship of The Horsepower Equine Assisted Learning (HEAL) Foundation to other health care and related agencies insofar as his/her care is concerned.
- To be fully informed, prior to or at the time of his/her initial appointment, of services available, and of related charges.
- To participate in the planning of his/her treatment, to be fully informed of any risks or hazards associated with his/her treatment, to refuse treatment, and to refuse to participate in experimental research.
- To not be arbitrarily discharged, or transferred to another service provider. Clients may be transferred or discharged only for clinical reasons, for his/her welfare, for other clients' welfare, or for nonpayment of services. Reasonable advance notice of any transferor discharge must be given to a family/client.
- To be encouraged and assisted to understand and exercise his/her rights and, to this end, have the right to voice grievances and recommend changes in policies and services to The Horsepower Equine Assisted Learning (HEAL) Foundation staff and outside representatives of his/her choice, free from restrain, interference, coercion, discrimination, or reprisal.
- To be free from mental and physical abuse, neglect, and exploitation and be free from chemical and physical restraints, except in emergencies, or as authorized in writing by his/her physician or other appropriately licensed professionals for a specified and limited period of time, and when necessary to protect the client from injury to him/herself or to others.
- No client/family shall be required to provide services for The Horsepower Equine Assisted Learning (HEAL) Foundation.
- To have the assurance of confidential treatment of his/her clinical records and may approve or refuse their release to any individual outside The Horsepower Equine Assisted Learning (HEAL) Foundation, except as otherwise provided by law, or a third party payment contract.
- To expect a reasonable response to his/her requests.
- To expect reasonable continuity of care.

Client Responsibilities

- To keep appointment or notify The Horsepower Equine Assisted Learning (HEAL) Foundation of necessary cancellations 24 hours in advance.

- To pay for services to the extent that he/she is able. Services may be refused if a client/family is able but unwilling to pay. The Horsepower Equine Assisted Learning (HEAL) Foundation has a sliding fee scale based on family income.

✳ To inform The Horsepower Equine Assisted Learning (HEAL) Foundation of relevant changes in location or status – address, telephone number, insurance coverage, etc.

✳ To follow through on service plan recommendations and procedures to which he/she had agreed or to specifically communicate his/her withdrawal of consent to any The Horsepower Equine Assisted Learning (HEAL) Foundation staff member.

To report any problems or changes, please contact your therapist. If you believe you have been denied any of the above rights, you may contact The Horsepower Equine Assisted Learning (HEAL) Foundation by mail at:
8366 Old Nokesville Rd., Catlett, VA 20119

The Horsepower Equine Assisted Learning (HEAL) Foundation Confidentiality Agreement & Equine Activity Liability Release and Risk Acknowledgement

Confidentiality Agreement:
I, _____ agree not to disclose any client names, treatment information or identifying information pertaining to any client, past, present or future, of *The Horsepower Equine Assisted Learning (HEAL) Foundation*. to anyone who is not affiliated with *The Horsepower Equine Assisted Learning (HEAL) Foundation*. This confidentiality agreement is effective the date of the signing of this agreement, and is forever binding after my association with *The Horsepower Equine Assisted Learning (HEAL) Foundation* ends.

Equine Liability Release and Risk Acknowledgement:

1. **Parties.** The parties to this document are The Horsepower Equine Assisted Learning (HEAL) Foundation (hereinafter "HEAL") and _____ (hereinafter "client").
(print client name here)

2. **Apportionment of Liability**. In consideration of client being allowed to attend, participate in, or observe activities sponsored or conducted by HEAL, or be present on the property on which HEAL conducts its activities, client does agree to hold harmless and release HEAL, its officers, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on HEAL's behalf and the owner(s) of any horse or other property used by HEAL, from all claims, demands, causes of action, and legal liability, whether the same be known or unknown, anticipated or unanticipated even if due to negligence and/or other clients' acts or omissions. Client does further agree to waive all rights which may otherwise arise from an injury to client or client's property, and shall not bring any claims, demands, legal actions or causes of action, against HEAL, those persons described above, or any person or entity, for any economic or non-economic losses due to bodily injury, death, or property damage arising out of the activities of HEAL or client's presence on or proximity to property used by HEAL.

3. **Indemnity**. Client agrees to be responsible for any and all damages, injuries, or loss of life caused by client or a horse in the care, custody and control of client, and to indemnify HEAL and all parties described above, for any losses or expenses (including attorney fees) which they incur in connection with claims related to client.

4. **Risks**. According to the North American Horseman's Association, numerous obvious and non-obvious inherent risks are always present in horseback riding and being around horses, despite all safety precautions. No horse is a completely safe horse. Horses are 5 to 15 times larger, 20 to 40 times more powerful and 3 to 4 times faster than a human. If a client falls from a horse to the ground it will generally be at a distance of 3 to 5 feet, and the impact may result in injury to the client. If a horse is frightened or provoked it may divert from its training and act according to its natural instincts which may include, but are not limited to: stopping short, changing direction or speed at will, shifting its weight from side to side, bucking, rearing, biting, kicking or running from danger. These risks exist for any person around a horse, whether mounted or on the ground. Client acknowledges these risks and states that she/he is not relying on HEAL to advise of all the risks.

5. **Acknowledgment and Assumption of Risks**. Client acknowledges that s/he bears responsibility for her/his own safety and client should not participate in any client activity unless she/he is confident that she/he can do so safely. Participation in equine activities with or conducted by HEAL constitutes a knowing and voluntary assumption of all risks associated with equine activities involving HEAL or being present on or using HEAL property (including but not limited to inherent risks and the risk of negligence by HEAL or others) which is a defense under Virginia law to any claim for injury or damage, and a bar to recovery.

6. Visitors. Should client bring to HEAL any person who is not a party to an Equine Activity Liability Agreement with HEAL, client agrees to educate them as to the risks of being around horses and horse operations, supervise them, be solely responsible for their safety, and to be financially responsible for any injury or loss caused by or suffered by any such person.

7. **Safety Rules.** Client agrees to follow such rules for safety as are attached or are subsequently provided to them, or posted. Client acknowledges that failure to follow HEAL safety rules or the directions of HEAL 's staff

may put her/him at risk of, or increase the risk of, personal injury.

8. **Premises Inspection.** Client has inspected the farm's premises and facilities and/or have in some other way satisfied himself/herself that the condition of the premises and the facilities will provide an adequate and reasonable level of safety for client and any guests, or visitors they bring on the premises.

9. **Other Terms.** This document states the entire agreement between the parties as to liability and may not be changed, except in writing signed by the parties. The benefits of this agreement, including the release of legal liability, waiver of rights, indemnity and covenant not to sue, are intended to benefit others, including HEAL's officers, directors, shareholders, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on HEAL's behalf and the owner(s) of any horse or other property used by HEAL. This agreement shall be binding upon HEAL, client, and client's heirs or estate, when signed by the parties. If any clause, phrase or work is in conflict with State Law then that single part is null and void. This agreement and acknowledgments shall remain in force until terminated by client through written notice to HEAL at the address above. The General Court of Prince William County, Virginia shall be the exclusive venue for any litigation between client and the parties described above.

Warning

Under Virginia Law an equine activity sponsor or an equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Va. Code Ann. § 3.2-6200 - 6302.

Client's Name:_____ Date:_____

Client's Signature:_____ Date:_____

The Horsepower Equine Assisted Learning (HEAL) Foundation
Acknowledgement of Receipt of Notice of Privacy Practices and Client Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company, collection agencies)
- The day-to-day healthcare operations of your practice including appointment confirmation calls to my home, cellular phone or place or place of employment.

I have also been informed of, and given the right to review and secure a copy of, your *Notice of Privacy Practices* that contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time-to-time and the most current copy of this notice will be provided upon request.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

_____

Print Client's Name

_____ Signed this ___ day of _____, 20___.

Client's Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ Other (please specify)

Consent For Data To Be Used In Research Studies

The Horsepower Equine Assisted Learning (HEAL) Foundation may ask that clients complete questionnaires prior to beginning therapy, during, and after competing therapy. The purpose of these questionnaires is to help the staff at *The Horsepower Equine Assisted Learning (HEAL) Foundation* learn about the effectiveness of Equine Assisted Psychotherapy (EAP).

The pre and post results of these questionnaires are later combined with results from other clients and are used to measure the program's effectiveness. Client's names are not used or associated with the results in any way. Basic information such as age and gender may be used when summarizing results, though client names remain entirely confidential.

Results from these questionnaires might also be summarized for publication in order to contribute to the literature and research available to help learn more about the effectiveness of EAP.

By signing this consent form, you are giving *The Horsepower Equine Assisted Learning (HEAL) Foundation*, permission to use the results of such questionnaires for research studies.

I understand the above and give my consent for results of this information to be used for research purposes. I understand that the names of clients will not be used in any way.

_____ _____

Client's Name Client's Date of Birth

_____ _____

Client Signature Date

Medical History, Emergency Information & Health Care Consent

Client's Full Name:_____ Date of Birth:_____

Street Address,_____

City, State, Zip:_____

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

Height:_____ Weight:_____ Tetanus Shot within the last 10 years: Yes [ ] No [ ]

Medications & Dosage	Taken Since	Prescribed by (Physician)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any areas of medical concern. If "yes," please explain in the Comments Section.

Areas	Yes	No	Comments
Auditory	☐	☐	_____
Visual	☐	☐	_____
Speech	☐	☐	_____
Cardiac (Heart)	☐	☐	_____
Circulatory (blood vessel disease)	☐	☐	_____
Pulmonary (lungs, breathing, asthma)	☐	☐	_____
Neurological (stroke, seizures)	☐	☐	_____
Muscular	☐	☐	_____
Orthopedic	☐	☐	_____
Allergies (drugs, bees, etc.)	☐	☐	_____
Learning disability	☐	☐	_____
Psychological impairment	☐	☐	_____
Diabetes (type 1 or type 2)	☐	☐	_____
Drug allergy/reactions	☐	☐	_____
Other	☐	☐	_____

By signing this form, I, _____ (please print client name) certify all information to be complete and true to the best of my knowledge.

Client's Name:_____ Date:_____

Client's Signature:_____ Date:_____

The Horsepower Equine Assisted Learning (HEAL) Foundation
Medical History, Emergency Information, & Health Care Consent

Client:_____ Phone Numbers 1._____ 2. _____

1st Emergency Contact_____ Relationship to Client _____ Phone _____

2nd Emergency Contact_____ Relationship to Client _____ Phone _____

Client's Primary Physician_____ Phone Number_____

Preferred Medical Facility: _____

Treating Psychiatrist if any:_____ Counselor/Therapist if any: _____

Emergency Medical Consent

The undersigned hereby grants to any *The Horsepower Equine Assisted Learning (HEAL) Foundation* affiliate/employee/intern/volunteer the authority to receive information pertaining to the emergency health care of the client named below and to make emergency health care decisions with respect to the client if the undersigned is unavailable to obtain such information or make such decisions.

Client's Name_____ Phone:_____

Address:_____

Client's Name:_____ Date:_____

Client's Signature:_____ Date:_____

++

Emergency Medical Non-Consent

If the undersigned does not desire to grant any *The Horsepower Equine Assisted Learning (HEAL) Foundation* affiliate/employee/intern/volunteer information or to make health care decisions for the client if the undersigned is unavailable, please initial on the line below and state the procedures to be followed if the client becomes ill or is involved in an accident and the undersigned is unavailable.

_____ I Do Not Consent to any *The Horsepower Equine Assisted Learning (HEAL) Foundation* affiliate/employee/intern/volunteer obtaining health care information or making emergency health care decisions concerning the client.

Procedures to be followed: _____

_____

_____

Client's Name:_____ Date:_____

Client's Signature:_____ Date:_____

The Horsepower Equine Assisted Learning (HEAL) Foundation
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to your health information. Please Read Carefully.

Protecting your privacy
Protecting your privacy and your medical information is at the core of our business. We recognize our legal and ethical obligation to keep your information secure and confidential whether it be orally, on paper, or in an electronic form.

How we might use your medical information
We will use your medical information for providing treatment, such as by looking at your records to use your medical history for current treatment; and/or payment, such as when a payer requests copies of our medical information to pay a claim; and/or for healthcare operations, such as for internal auditing. We may contact you to help provide you with information concerning your health. We may also contact you to remind you of an upcoming appointment, taking care not to reveal any of your medical information. You have a right to ask us not to contact you using this method. I understand that as a part of my healthcare, The Horsepower Equine Assisted Learning (HEAL) Foundation originates and maintains health records describing my health history, symptoms, examination on test results, diagnosis, treatment, and any plans for future care of treatment for up to seven years after the date of my last session at The Horsepower Equine Assisted Learning (HEAL) Foundation. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Use and disclosure for your health information in certain special circumstances; the following circumstances may also require us to use or disclose your health information without your consent or authorization:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. 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. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding your health information

1. You can request that The Horsepower Equine Assisted Learning (HEAL) Foundation 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. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information 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.

3. You have a right to ask for complete accounting of disclosures that were not authorized or otherwise permitted as listed above. You may revoke your authorization to disclose your medical information at any time.

4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including client medical records and billing records. In order to receive a copy of your records, The Horsepower Equine Assisted Learning (HEAL) Foundation will charge you fifty cents ($.50) per page. You must submit your request in writing and in person to The Horsepower Equine Assisted Learning (HEAL) Foundation, Attn: Office Manager. Before receiving your records, you must make an appointment with your therapist, so he or she can go over your records with you, in case you have any questions.

5. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for The Horsepower Equine Assisted Learning (HEAL) Foundation. To request an amendment, your request must be made in writing and submitted to The Horsepower Equine Assisted Learning (HEAL) Foundation, Attn: Office manager. You must provide us with a reason that supports your request for amendment.

6. You have a right to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. The Horsepower Equine Assisted Learning (HEAL) Foundation reserves the right to change their notice and practices and if the terms do change, you may obtain a revised Notice by contacting The Horsepower Equine Assisted Learning (HEAL) Foundation by mail or by asking a therapist.

7. You have a right to file a complaint. If you believe that your privacy rights have been violated, you may file a complaint with (1) The Horsepower Equine Assisted Learning (HEAL) Foundation or with (2) the Secretary of the Department of Health and Human Services. Both addresses are provided at the bottom of this form. All complaints must be submitted in writing. To file a complaint with The Horsepower Equine Assisted Learning (HEAL) Foundation, contact the Office Manager. You will not be penalized for filing a complaint.

8. You have a right to provide an authorization for other uses and disclosures. The Horsepower Equine Assisted Learning (HEAL) Foundation will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions about this notice or our health information privacy practices, please contact The Horsepower Equine Assisted Learning (HEAL) Foundation.

The Horsepower Equine Assisted Learning (HEAL) Foundation
8366 Old Nokesville Rd.
Catlett, VA 20119

US Dept. of Health and Human Services
200 Independence Ave., S.W.
Washington, DC, 20201
Telephone: (202) 619-0257
Fax: 1-877-696-6775
Website: www.hhs.gov/