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 Galloping Acres Foundation, INC 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 GALLOPING ACRES

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 Galloping Acres Foundation, INC *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)

EQUINE ACTIVITY LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISK

I, the undersigned participant, hereby agree to the provisions of this Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risk Agreement ("this Agreement") with GALLOPING ACRES, LLC (the "Equine Professional") and TALL CEDARS FARM, INC. (the "Owner"), and Galloping Acres Foundation Inc. on behalf of myself and each minor participant for whom I am signing this Agreement (as named below), as follows:

1. I/we agree to follow all instructions given or rules established by the Equine Professional or any of the Equine Professional's employees or other agents concerning my/our use of any horse or of any equipment or gear provided by the Equine Professional. It is highly recommended for safety reasons that a riding helmet be worn while engaged in equine activities. Please indicate whether or not you desire to wear a riding helmet: YES_____ NO_____ INITIALS_____ . I hereby accept full responsibility for all injuries that might occur as a result of failure to wear a riding helmet.
2. I/we have full and complete notice and understanding of the many risks inherent in equine activities which may cause, contribute to or result in SERIOUS INJURY OR EVEN DEATH or damage to property (the "Risks"), regardless of previous training and past performance of the horse including but not limited to the following:
    1. (a) Horses have a propensity to behave in dangerous ways;
    2. (b) It is not expected that anyone will be able to predict or foresee a horse's reaction to excitement,

       weather conditions, sound, movements, objects, persons, animals, reptiles, birds or insects, nor the

       effects of any such reactions;

    3. (c) Surface and subsurface conditions pose many potential hazards, both obvious and hidden;
    4. (d) There is always a risk that tack or harness may slip or break or that the horse or the participant may

       become entangled in tack, harness or vehicles used in an equine activity; and

    5. (e) There is a risk of the participant falling from or otherwise becoming unstable on a horse or a

       vehicle used in an equine activity or for the horse to trip and/or fall down without warning.

3. I/we have full and complete notice and understanding that this Agreement and all equine activities provided by the Equine Professional are governed by the Virginia Equine Activity Liability Act (Code of Virginia §3.1-796.130, §3.1-796.132, §3.1-796.133 et seq., Please see exhibit A), as it may now provide or be hereafter amended ("the Act"), which Act is hereby incorporated in this Agreement by reference; that all terms defined by the Act shall have the same meaning herein; and that this Agreement shall be so construed as to provide to the Equine Professional the fullest protection of a release, waiver of right to sue and assumption of all risk which is afforded by the Act.
4. I/we hereby RELEASE and WAIVE all rights which 1/we may have or may hereafter have against the Equine Professional and/or the Owner for death, personal injury or property damage which is in any way associated with the Risks or otherwise covered under the Act; 1/we hereby WAIVE any right to sue or to bring any action against the Equine Professional and/or the Owner in connection therewith including any negligent act or omission by either of them or by any employee or agent of either of them; 1/we hereby agree to INDEMNIFY and HOLD HARMLESS the Equine Professional and/or the Owner from and against any such suit or action and agree to pay any attorney fees which may arise if any such suit or action is filed; and 1/we hereby expressly ASSUME ALL RISKS AN]) DANGERS of death, personal injury and property damage which are in any way associated with the Risks or otherwise covered under the Act.
5. 1/we hereby authorize and consent to any emergency medical care which may be administered as a result of injury or sickness caused by or incurred in the course of any equine activity.

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

6. To the extent possible, this Agreement shall be construed in such manner as will render each provision fully enforceable; but if any provision of this Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Agreement shall continue in full force and effect.

Initials _____

7. If this Agreement is executed for and on behalf of a minor participant named below, the undersigned participant hereby warrants and represents that he or she is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor participant, his heirs, personal representatives, successors and assigns. in any event, this Agreement shall be binding upon the heirs, personal representatives, successors and assigns of the participant.

8. Each and every right and benefit of the Equine Professional and/or the Owner hereunder shall also accrue to the benefit of each officer, agent, employee, director, shareholder, member, partner, heir-at-law, personal representative, successor and assign of the Equine Professional and the Owner including without limitation every waiver, release, indemnification and agreement to hold harmless.

I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING EQUINE LIABILITY RELEASE, WAIVER OR RIGHT TO SUE AND ASSUMPTION OF ALL RISKS. I HAVE HAD AN OPPORTUNITY TO CONSULT WITH MY OWN ADVISORS ON ALL QUESTIONS IN CONNECTION THEREWITH, AND I HAVE NOT RELIED UPON THE EQUINE PROFESSIONAL OR THE OWNER FOR ANY ADVICE OR EXPLANATION IN CONNECTION THEREWITH. I ACKNOWLEDGE THAT I HAVE A COPY AND HAVE A FULL AND COMPLETE UNDERSTANDING OF THE VIRGINIA EQUINE LIABILIY ACT. I UNDERSTAND THAT, BY SIGNING THIS DOCUMENT, I MAY HE WAIVING AND RELEASING CERTAIN IMPORTANT RIGHTS WHICH I MIGHT HAVE IF I DID NOT SIGN THIS AGREEMENT. I AM SIGNING THIS DOCUMENT FREELY, VOLUNTARILY AND WITHOUT ANY COERCION.

ADULT PARTICIPANT'S FULL NAME AND ADDRESS (Please Print):

_____

_____ _____

_____

Signature

_____ Date

EACH MINOR PARTICIPANT FOR WHOM PARTICIPANT IS SIGNING (Print Name):

_____ _____

APPLICATION FOR MENTAL HEALTH SERVICES (EQUINE THERAPY)

PHOTO RELEASE/ MEDIA CONSENT

I DO ___consent to and authorize the Galloping Acres Foundation, INC to take or have taken still and/or moving photographs, films and/or television pictures, and consent and authorize Galloping Acres Foundation, INC and/or it advertising agencies, news media and any other persons associated with the Galloping Acres Foundation, INC to use and reproduce the photographs, films, and/or 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 materials, books, and/or clinical materials. With respect to the foregoing matters, no inducements or promises have been made to us to secure m signature to this release other than the intention of the Galloping Acres Foundation, INC Therapeutic Riding Center to use or cause to be used such photographs, films, and pictures for the primary purpose of promoting and aiding the center and its work.

Date: _____ Signature: _____ (Volunteer, Participant, independent contractor

Signature: _____ (Parent/Guardian ~ if Volunteer under 18)

,I DO NOT___, for reasons I am not obligated to disclose, give consent for photographs, either still or moving or any television or news media, to be taken of myself by the Galloping Acres Foundation, INC or any persons working on behalf of said center. I understand a Red Dot will be placed on the sign-in sheet to reflect photographs, etc., are NOT allowed.

Date: _____ Signature: _____ (Volunteer, Participant, independent contractor

Signature:_____ (Parent/Guardian ~ if Volunteer under)

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 Galloping Acres Foundation, INC. I authorize Galloping Acres Foundation, INC 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 Galloping Acres Foundation, INC 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 Galloping Acres Foundation, INC I wish the following procedure to take place (***LIST PROCEDURE ON LINE):*** _____

Note:* Galloping Acres Foundation, INC i*s unable to guarantee that emergency medical treatment will be withheld

_____ _____

Signature of Participant/Volunteer/Guest/Independent Contractor/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 Galloping acres Foundation, INC; 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 regarding my future services or attendance during this pandemic or any infectious diseases outbreak.

Galloping Acres Foundation, INC 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 independent contractor Date

_____

Signature of Participant/Volunteer/Guest/independent contractor/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 Galloping Acres Foundation, INC could increase your risk of contracting COVID-19, and Galloping Acres Foundation, INC cannot guarantee that you will not become infected with COVID-19.
Acknowledgment of Risk, 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 Galloping Acres Foundation, INC or others resulting from the assumption of such risks; and (2)Galloping Acres 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 aways permit social distancing of six feet per person.

Galloping Acres Foundation, INC 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 Galloping Acres Foundation, INC current policies and requirements for participation in or observation of activities at the Center in response to such guidance and protocols Galloping Acres Foundation, INC, COVID-19 policies and requirements"). The undersigned acknowledges and agrees that Galloping Acres Foundation, INC 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 always comply with** Galloping Acres Foundation, INC **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 Galloping Acres Foundation, INC I hereby forever release, waive, discharge, and hold harmless, and agree not to sue or assert any claim against, Galloping Acres Foundation Inc (including its directors, independent contractors, and volunteers) for any loss or damages arising from such exposure or infection. I understand that by signing this document, all liability of Galloping Acres Foundation, INC (including its directors, independent contractors, volunteers), 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 independent contractors Date: _____

_____
Signature of Participant/Volunteer/Guest/independent contractors, 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 Galloping Acres Foundation, INC 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 Galloping Acres Foundation, INC 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:

Galloping Acres Foundation
14326 Boondock Lane
Montpelier VA 23192

I understand that:

- If 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 proceeding 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

Mental Health Financial Policies

- Galloping Acres Foundation, INC does not bill insurance companies for Mental Health services. Payment is due at the time of service in the form of cash or check. Checks should be made to Galloping Acres Foundation, Inc
- **We require a 24-hour cancellation notice or a $50.00 missed appointment fee will apply**.
- Fees for Mental Health are
    - $50 a session
- Payment for Mental Health services are due in full at the time of service.
- There is a $25 returned check fee for any check returned by our bank for insufficient funds.

I have read and understand the financialpolicies: _____

Signature Date

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 is 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 Galloping Acres Foundation, INC is not affiliated with your insurance network, we will be happy to provide you with whatever paperwork 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.

Galloping Acres Foundation, INC 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 its terms during our professional relationship.

Printed Name:_____ Date:_____

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