REGISTRATION

Client: ___________________________ Date of Birth: _________________ Age: _____
Address: ____
City, State: ___________________________________ Zip Code:___________________
Parent or Legal Guardian Name(s): ____
Home #: _____________________________Cell #: _______________________________
Email Address: ___________________________________Emergency #: _____________
School Attending: ____ Grade:__________
Court Involvement: _____________________________ On Probation: _______________
Other Agencies involved with client: ____

CONSENT AND LIABILITY RELEASE

I, ____________________________, hereby request that the client named above be accepted into equine assisted psychotherapy program operated by Special Spirit. I acknowledge Special Spirit Personnel have fully explained to me the scope of the Equine-Assisted Psychotherapy (EAP) program, including the potential for injury which can occur from riding horses, caring for horses or being involved in therapeutic activities that include horses. Because of the potential benefits of the EAP program, I hereby waive any claim which I or the client may have against Special Spirit, officers, employees, volunteer, or contract personnel arising out of any injury which the client may sustain while involved in the EAP program, unless caused by the willful misconduct or gross negligence of Special Spirit, its employees, officers, volunteer, or contract personnel.

I acknowledge the risks and potential risks of horse-related activities and activities in and around a facility where horses are kept and farm machinery operated. However, I feel that the possible benefits to me/my son/my daughter/my ward outweigh the risk assumed. Intending legally to bind myself, my heirs, and assigns, executors or administrators, I hereby waive and release forever all claims for loss or damages of any kind against Special Spirit, Inc., Moonshadow Ranch, Eva Lund and its Board of Directors, instructors, therapists, aids, volunteers, contract personnel and employees for any and all injuries and losses that I/my son/my daughter/my ward may sustain while participating in the Special Spirit equine programs. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at Special Spirit Inc. voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that Special Spirit Inc. and the property owners are materially relying on this waiver and assumption of risk in allowing me/my son/my daughter/my ward to participate in activities at Moonshadow Ranch Home of Special Spirit.

I have read this release

_____________________________________   ______________________________

Signature of Client/Participant Date

__________________________________ ____________________________

Signature of Parent/Guardian Date

Authorization for Emergency Medical Treatment

Name: ____________________________ DOB: _________ Phone: _________________

Address: ____

Physician's Name: __________________________ Medical Facility: ________________

Health Care Insurance: _________________________ Policy #: ____________________

Allergies to Medications: ____

Current Medications: ____

In the event of an emergency contact:
Name: _____________________ Relation: ____________ Phone: ___________________

Name: ______________________ Relation: ____________ Phone: __________________

In the event emergency medical treatment is required due to illness or injury during the process of receiving services or while being on the premises of Special Spirit Inc. facility, I hereby authorize the Special Spirit Inc. staff to secure and retain medical treatment and transportation if needed and to release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and treatment procedure deemed necessary as life saving by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _______________ Consent Signature: ___________________________________
Client, Parent or Legal Guardian

Non-Consent Plan

I do not give consent for the emergency medical plan listed above and instead request the following procedures to take place: ____
____

Date: _______________ Consent Signature: ___________________________________
Client, Parent or Legal Guardian

DISCLOSURE AND CONSENT STATEMENT

The following is to inform you of the polices and therapeutic practices of Special Spirit EAP Services. Please read this information carefully. If you have any questions please feel free to discuss this with your therapist.

CLINICAL AND THERAPIST INFORMATION

A primary commitment of Special Spirit EAP services is to provide you with quality therapy services. However, no therapist can guarantee that therapy services will be effective for you. This statement is intended to convey pertinent information regarding our services, allowing you to make choices based on correct information. All our therapists have either Masters or Doctoral level degrees and work in partnership with an EAGALA certified horse professional. Therapists are either licensed by the State as Professional Therapist or they are working toward licensure under an approved supervisor. We endeavor to maintain a high level of competence and we adhere to professional, legal and moral standards. Equine Assisted Psychotherapy is a team approach to counseling with a therapist, horse professional, and a horse. We seek to integrate the emotional, spiritual, physical, relational and mental elements in the counseling process. A variety of techniques and approaches are used. If you have any further questions regarding your therapist's training or professional approach, please feel free to ask your therapist.

APPOINTMENT AND FEE POLICY

I. The normal fee for our services is $_______ depending on treatment design. Fees must be paid out of pocket. We are not set up to bill insurances directly. All those who have insurance to assist with this fee are expected to handle payment for services and bill their insurance company themselves. We are willing to provide receipts needed to do so. It is your responsibility to see that the fee is covered. If you will be filing on your insurance, it is IMPORTANT that you realize we must assign a diagnosis, and that diagnosis will permanently be on your medical record. Payment is due at the time services are rendered.

II. If you are unable to keep your appointment, please five a 24-hour notice so that we may utilize the time to assist someone else. Unless there is an extreme emergency, we will charge you one half of your fee if a 24-hour notice is not given and the full fee for missed appointments with no notice. The fees are to be paid by the next appointment. I have read and understand the appointment and fee policy. ______________ (initial)

CONFIDENTIALITY INFORMATION

I. Content obtained in the therapy sessions will be handled professionally and confidentially. This information will be used by your therapist, the horse professional, and the supervisor for your therapeutic benefit. If for treatment purposes, we need information from another party, we will ask you to sign a Release of Information Form.

II. To further maximize the benefits of therapy activities and to assess these benefits, you may be asked to complete a pre-test before starting therapy and post-test after completion of therapy. The data collected will be used to improve therapy services for others in the future and to provide data needed in grant applications. No personal information will be disclosed in these findings.

III. **Confidentiality is forfeited** for any of the following:

a. If you posed serious physical danger to yourself or another person.
b. If you disclose that you or another person has physically or sexually abused or molested a child or an incompetent or disabled person.
c. If you disclose that a child, an incompetent or disabled person is suffering from neglect.
d. Defense of claims brought by client against the therapist and/or horse professional of Special Spirit EAP Services.
e. Reporting to relevant agencies such as court and insurance company as may ne ordered by the Court system or for third party payment.
f. If you disclose that you have committed a crime.

If any of a-f apply immediate action must be taken. I have read and understand the Confidentiality Information _______________ (initial)

CONSENT TO TREATMENT

After thoroughly reading, understanding and receiving a copy of the above information, I give my consent to treatment (including assessment and therapy) to Special Spirit EAP Services. I have read and understand the policies and information state above.

____ ____________________

Signature Date

Equine Assisted Therapy -- Intake Inventory

CLIENT INFORMATION	FAMILY/SPOUSE INFORMATION
Name: ____________________ Sex: F M	Spouse/Parent: ____________________
Address: ____________________	Address: ____________________
City, Zip: ____________________	City, Zip: ____________________
Home Phone: ____________________	Home Phone: ____________________
Cell Phone: ____________________	Cell Phone: ____________________
Employer: ____________________	Employer: ____________________
SS#: __________ DOB: __________ Age: ____	SS#: __________ DOB: __________ Age: ____
Married Remarried Single Separated Divorced	Married Remarried Single Separated Divorced
Court Involvement: ____________________	
Other Agencies Involved: ____________________	
____________________	

Education: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

Other (list type and years): ____________________

Information on children –

Name:	Age:	Sex:	Living:		School Grade:
____________	______	**M F**	**In Home**	**Out of Home**	____________
____________	______	**M F**	**In Home**	**Out of Home**	____________
____________	______	**M F**	**In Home**	**Out of Home**	____________
____________	______	**M F**	**In Home**	**Out of Home**	____________

PARENTAL CONSENT

MUST BE COMPLETED FOR ALL CLIENTS UNDER AGE OF 18

I, legal guardian, give my authorization for EAP Services to counsel with the above mentioned minor.

Signature: ____________________ Date: ____________________

HEALTH

How would you rate your physical health? Very Good Good Average Poor

If you are presently taking any medication, please list: ____________________

For what condition: ____________________ PCP contact info:____________________

Name of referring Physician, if any: ____________________

THERAPY HISTORY

How did your hear about Special Spirit EAP Services?

Friend Family Member Phone Book Brochure Other: ____________________

How you ever been see or treated by a psychiatrist or therapist? Yes No

If yes, how long: _________

Please state in a few sentences the major therapy need you have at this time:

____

____

____

____