SHADOW HILLS RIDING CLUB
NATURAL EQUINE ASSISTED THERAPIES

10263 La Canada Way, Shadow Hills CA 91040 • 818-352-2166

INTAKE PACKET

- ☐ Client and clinical Information
- ☐ Authorization for Emergency Medical Treatment
- ☐ Client Consent Form
- ☐ Informed Consent for Clinical Supervision
- ☐ Liability Release
- ☐ Photo and Video Release Form
- ☐ Activity Agreement
- ☐ Consent to Treat a Minor

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CLIENT INFORMATION

Name _____
(first) (middle) (last)

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work) _____

Other numbers (cell) _____(fax)_____(pager)_____

Can we leave a message? ____ yes ____ no At ____home ____work ____pager

e-mail _____

DOB _____ Age ____ Ethnicity_____ Gender _____

Soc Sec # _____ ____ _____

How did you find us? _____

In emergency, please call:

Name _____ Relationship _____

Address _____ Phone _____

CLINICAL INFORMATION

1. THERAPY EXPERIENCE

Previous counseling/therapy: Please include when, how long and reason for ending

2. MEDICAL HISTORY

Approximate date of last physical check-up _____

Significant past physical problems

Head Trauma Yes ____ No ____ Circumstances and date

Psychiatric hospitalizations Yes ____ No ____ Approx dates _____

Other recent hospitalization Yes ____ No ____ Approx dates _____

Major surgeries (Type and Date)

DRUG USE

Drugs (Prescribed or not) Type, doses and duration of use:

Past

Current

Complications for use if any, (physical, occupational, relational)

3. FAMILY ILLNESSES

Please note significant physical problems, nervous breakdowns, depression, alcoholism, mental illness

4. PERSONAL HISTORY

Highest educational level achieved _____

Current occupation _____

Marital status, Single _____

Divorced _____ When? _____ How long were you married? _____

Married _____ How long? _____

Children (age[s], name[s]) _____

Living arrangement (house, apartment, members of household)

Reason for seeking therapy at this time

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name: _____ DOB: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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 Shadow Hills Riding Club facility, I hereby authorize the Shadow Hills Riding Club 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

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CLIENT CONSENT FORM

Please read carefully. Sign one copy and keep a copy for your records and future reference.

1. As your therapist I will maintain confidentiality of all information disclosed in therapy. However, there are certain situations where I am **required by law** to reveal information to other persons or agencies and may do so without your written consent. These situations include the threat of bodily harm to yourself or another person, evidence of child abuse or elder abuse, or the issuance of a subpoena by a court of law.

2. All therapists seek continual opportunities for professional development and therefore there may be an occasional need for peer consultation with other health care professionals in the format of anonymous case presentations.

3. Brief records of therapy sessions will be kept in a locked filing system in my office.

4. In the case of an emergency you may leave a message on my confidential voice mail which I check several times a day. If you are in immediate need of assistance, please call 911.

5. Each session is 50 minutes long and you are responsible to pay for session at the beginning of each session. Having your check made out *before* therapy will insure that your therapy time is not taken up with check writing.

6. ***Please note:*** There is a policy of a **24 hour notification of cancellation** and thus the full fee for late cancellations or missed appointments will be applied.

7. You may make use of any insurance that includes mental health benefits. As you are responsible for your fees, please have your insurance company reimburse you directly. At your request, I will send you a statement at the end of each month with includes the information required by your insurance company. You may directly forward this statement with your claim form to your insurance company.

8. By signing this statement you agree to receive psychotherapeutic care from _____, for yourself and/or your family member(s).

Signature: _____ Date: _____

Name: _____

Therapist: _____

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Client's Name: _____

INFORMED CONSENT FOR CLINICAL SUPERVISION

I. It is the policy in this Center that all clinical work by staff and interns is supervised by senior staff members. The purpose of the requirement is to provide comprehensive services with the highest degree of Quality Assurance.

In this Center, a number of the psychotherapists are interns from formal training programs in Social Work. They are here as part of their program.

II. I understand that I am receiving services from_____ who is unlicensed, and under the supervision of _____ who is a licensed social worker.

III. I hereby acknowledge the policy of clinical supervision and give my consent to it.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Client Date

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LIABILITY RELEASE:

Name of Participant/Parent/Guardian/Conservator_____

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 herby waive and release forever all claims for loss or damages of any kind against Shadow Hills Riding Club, Rockin W. Ranch, Inc., Johnny Higginson, Andrew Mikiel, it's Board of Directors, instructors, therapists, aids, volunteers and employees for any and all injuries and losses that I/my son/my daughter/my ward may sustain while participating in the Shadow Hills Riding Club program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at Shadow Hills Riding Club 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 Shadow Hills Riding Club 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 Shadow Hills Riding club.

_____ _____
Signature of Client/Participant Date

_____ _____
Signature of Parent/Guardian Date

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PHOTO AND VIDEO RELEASE FORM

I, _____,

____ consent to and authorize

____ do not consent to nor do I authorize

the use and reproduction by Shadow Hills Riding Club of any audio/visual materials taken of me/my son/my daughter/my ward for distribution to the public for promotional printed materials, educational activities or for any use for the benefit of the program.

I acknowledge that I am [ ] over the age of 18
[ ] the legal guardian of _____

Date_____

Signature_____
(Participant, Parent or Caregiver)

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ACTIVITY AGREEMENT

As a chosen participant in an equine-assisted activity, I agree to the following:

1. I will not smoke on the property of Shadow Hills Riding Club – in the barn, in the arena, or anywhere on the grounds.

2. I will respect our session space that includes the office, the barn, the grounds and the arena located at 10263 La Canada Way, Shadow Hills, called Shadow Hills Riding Club.

3. I will be respectful of the horse owners, their horses and their property while on the grounds of Shadow Hills Riding Club.

4. I will not run or act in a manner that may frighten the horses or individuals that I encounter at Shadow Hills Riding Club, knowing that to do so may endanger the safety of others and myself.

5. I agree to assume all financial responsibility for physical and personal loss or property damage/injury I cause.

6. Other:_____
_____
_____

_____ _____
Signature of Parent/Guardian Signature of Client

_____ _____
Signature of Therapist Date

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CONSENT TO TREAT A MINOR

By signing this statement, I give consent for Shadow Hills Riding Club to treat in psychotherapy the following minor who is under my care and for whom I am legally responsible:

Name of minor _____

Name of the parent/guardian _____

Relation to the minor _____

_____ _____
Signature of Parent/Guardian Date