



CONSENT FOR THERAPY TREATMENT

I, the undersigned, am agreeing to treatment, for myself and/or for a minor child or children for whom I am the parent/guardian, through H.O.R.S.E. Inc.

I, and my minor child or children, if applicable, have read all forms, releases and paperwork provided to me and agree to conduct myself and hold my minor child(ren) responsible for conducting him/her/themselves in accordance to the paperwork provided. This paperwork (hereinafter referred to as "the contract") totaling 14 pages, includes:

- 1) Consent For Therapy Treatment Agreement
- 2) Client & Insurance Data Form
- 3) Current Services
- 4) Authorization to Seek Emergency Medical Treatment and/or to Receive Medical Information
- 5) Confidential Medical History Information
- 6) Participant Agreement, Release, and Acknowledgement of Risk
- 7) Activity Agreement
- 8) Fee Agreement
- 9) Video and Photograph Release
- 10) Summary of Notice of Privacy Practices

I agree that I have read, reviewed and understand the State of Missouri's Equine Activity Liability Act Warning which states:

MISSOURI WARNING

UNDER MISSOURI LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO THE REVISED STATUTES OF MISSOURI, RSMO 537.325.

I/We understand that for the purpose of these activities, H.O.R.S.E. employees and/or contractors are considered agents of the organization and shall be considered "equine professionals" directed under the guidance of a lead equine professional. Any and all volunteers acting in H.O.R.S.E.'s behalf supporting these activities shall also be considered equine professionals. My/Our participation in EAL program activities per this Agreement is deemed "equine activities" under the above statute.

I have received, for my records, and I have read the H.O.R.S.E. HIPPA Notice of Privacy Practices and More document which contains HIPPA notices, clothing requirements, and FAQ.

✍		
SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE
✍		
SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE

IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

✍	✍	
SIGNATURE OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE

Tell us how you heard about the H.O.R.S.E. program.

Yellow Pages
 Brochure
 Internet
 Magazine or newspaper _____
 Doctor
 Counselor
 Friend or Family member
 Other

Client & Insurance Data Form
 Date: _____
 Home Phone: _____
 Cell Phone: _____

 Must include
 front & back copy
 of insurance card

CLIENT INFORMATION	Full Name:				DOB:
DX:	Axes: I		II	III	IV
V Gaf Score	Soc. Sec. #		If in school what grade:		
Address:					
Email:			School/Work:		
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other					
PERSON(S) FINANCIALLY RESPONSIBLE (Person Responsible for payment of account)					
Full Name:			Relation to the client:		
Address:			DOB:		
Home Phone:		Cell Phone:		Soc. Sec.#	
Employer:			Occupation:		
Business address:			Business Phone:		
PRIMARY INSURANCE					
Subscriber's Full Name:			Relation to the client:		
Address:			DOB:		
Home Phone:		Cell Phone:		Soc. Sec.#	
Employer:			Occupation:		
Business address:			Business Phone:		
Insurance Company:			Subscriber's #:		
Contract #:			Group #:		
ADDITIONAL INSURANCE					
Is the client covered by additional insurance <input type="checkbox"/> Yes <input type="checkbox"/> No					
Subscriber's Full Name:			Relation to the client:		
Address:			DOB:		
Home Phone:		Cell Phone:		Soc. Sec.#	
Employer:			Occupation:		
Business address:			Business Phone:		
Insurance Company:			Subscriber's #:		
Contract #:			Group #:		
Subscriber's Name:			Relation to the client:		
Address:			DOB:		
Home Phone:		Cell Phone:		Soc. Sec.#	
Employer:			Occupation:		
Business address:			Business Phone:		
Insurance Company:			Subscriber's #:		
Contract #:			Group #:		

Assignment of Insurance Benefit and Release of Information to Insurance Company: I certify that I, and /or my dependent(s) have insurance coverage with _____ and assign directly to H.O.R.S.E. Helping Others Reach Success & Excellence, Inc. all insurance benefits, if any, otherwise payable for services given. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. H.O.R.S.E. may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I agree to notify H.O.R.S.E. Inc., immediately of any changes in address or insurance coverage or I will be responsible for any resulting uncovered services.

 Signature of Client over 18, or Parent, Guardian or Legal Representative
 Relationship to client: _____

 Please Print
 Date: _____

CURRENT SERVICES

If the client is currently receiving other therapy services, please list services under appropriate heading. This is so that we are able, if appropriate to his/her treatment, to coordinate and consult with other service providers to help your child receive the best possible treatment.

OUT OF HOME PLACEMENT (foster homes, group homes). Please fill out additional contact information on this page.

Check here if the client does not currently have any other services in place or does not wish us to consult with other service providers.

Yes	No	Service	Name	Phone #
		Psychiatrist		
		Counselor (Include type of counselor) *		
		Special Education (Name of teacher)**		
		Occupational Therapist		
		Physical Therapist		
		Speech and Language Therapist		
		Foster Placement (Complete information below)		
		Group Home Placement (fill out information below)		
		Mental or Behavioral Health, caseworker		
		Other		

Any other behavior therapies, other psychotherapists involved with child, school counselors etc... list under "Other"
 ➤If possible, attach a copy of Individual Education Plan (IEP)

DIVISION OF FAMILY SERVICES (DFS)

CASEWORKER NAME		OFFICE PHONE		CELL PHONE	
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FOSTER HOME/GROUP HOME CONTACT INFORMATION

FOSTER PARENTS or GROUP HOME CONTACT NAME	ADDRESS (street, city, state, zip)	Home Phone	Work Phone	Cell / Pager
Email address, if any:				
Email address, if any:				

THIS IS A TWO PART FORM, ONLY SELECT ONE PART TO SIGN OFF ON.

≡ CONSENT ≡ Authorization for Emergency Medical Treatment & Confidential Medical Info.

The undersigned hereby grants to H.O.R.S.E., Inc., and/or Brenda J. Wright, and/or employees or contractors who are considered agents representing the organization H.O.R.S.E. the authority to secure emergency medical treatment for Participant if the undersigned and/or Participant's emergency contact person is unavailable to make such decisions. With regards to your physical well being and in order for H.O.R.S.E. Inc. to ensure that the activities that you might be engaged in will be suitable for your over all health, the following form "Confidential Medical History Information" should be completed accurately. **If there is any health issue that should prevent you from performing various physical tasks, such as lifting up to 60 pounds or performing strenuous activities and if there is any health issue or medications that a emergency doctor may need to be aware of in case of an emergency please list those health issues where appropriate.** This information is only for the benefit of helping ensure your physical well being during activities.

PRINT CLIENT/PARTICIPANT NAME	ADDRESS	PHONE
PRINT CLIENT/PARTICIPANT NAME	ADDRESS	PHONE

EMERGENCY CONTACT

Contact Name:	
Contact Name:	
Physician Name:	
Preferred Medical Facility:	

Contact Phone:	
Contact Phone:	
Physician Phone:	
MEDICAID Number or Health Insurance Co, if applicable:	

(Please attach a copy of the front and back of your insurance card to this form) . Failure to attach this card may prevent emergency medical attention from being secured.

SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE
SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE

IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

SIGNATURE OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE
ADDRESS OF PARENT/GUARDIAN	PHONE	

NON-CONSENT

If the undersigned **does not desire to grant** H.O.R.S.E. Inc. and/or Brenda J. Wright or any H.O.R.S.E. agents representing the organization authority to secure emergency medical treatment for the client if the undersigned is unavailable, or the emergency contact person is unavailable, please initial the box below and state on the reverse side of this form 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 Brenda J. Wright or any H.O.R.S.E. agents obtaining health care information or making health care decisions concerning the client.

SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	PHONE NUMBER	DATE
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IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

SIGNATURE OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE
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CONFIDENTIAL
Medical History Information

CLIENT ①	
NAME	
DOB	
ADDRESS	
PARENT/GUARDIAN*	
TETANUS SHOT (Circle One)	Yes No
HEIGHT	
WEIGHT	
MEDICATIONS	
SIDE EFFECTIVE THAT WE SHOULD KNOW ABOUT? Dry mouth, dizziness, sensitivity to sun, etc.	

CLIENT ②	
NAME	
DOB	
ADDRESS	
PARENT/GUARDIAN*	
TETANUS SHOT (Circle One)	Yes No
HEIGHT	
WEIGHT	
MEDICATIONS	
SIDE EFFECTIVE THAT WE SHOULD KNOW ABOUT? Dry mouth, dizziness, sensitivity to sun, etc.	

Please indicate if client has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment, using back of form if necessary. If form is being filled out for family therapy, please place name of family member with the problem on the line along with applicable number (①, ②) following the issue.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Auditory _____
<input type="checkbox"/>	<input type="checkbox"/>	Visual _____
<input type="checkbox"/>	<input type="checkbox"/>	Speech _____
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac _____
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory (Incl. clotting disorders) _____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary _____
<input type="checkbox"/>	<input type="checkbox"/>	Neurological _____
<input type="checkbox"/>	<input type="checkbox"/>	Muscular _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic (Incl. spinal/joint abnormalities) _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma. If yes, do you have a rescue inhaler? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Learning Disability _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Note restrictions if any) _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

I have filled out this medical information sheet to the best of my knowledge. I understand that the information provided will be kept confidential. I also understand that equine therapy may be physically challenging and I take full responsibility for deciding whether or not I, or my minor child, should participate. By signing this form, I am accepting the physical nature of Equine Assisted Therapy and am agreeing to participate or agreeing for my minor child to participate.

 _____
SIGNATURE OF CLIENT/PARTICIPANT

PRINT NAME

DATE

 _____
SIGNATURE OF CLIENT/PARTICIPANT

PRINT NAME

DATE

IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

 _____
SIGNATURE OF PARENT/GUARDIAN

 _____
SIGNATURE OF PARENT/GUARDIAN

DATE



PARTICIPANT AGREEMENT, RELEASE. AND ACKNOWLEDGEMENT OF RISK

In consideration of my receiving the services from H.O.R.S.E. Incorporated, Brenda J. Wright, individually and d/b/a Eveningstar Equestrian Ranch, 19021 Long Grove Road, Higginsville, MO 64037, and/or Big River Ranch, LLC, 20111 Goodloe Orchard Road, Lexington, MO 64067, and/or from any of their agents, owners, officers, directors, volunteers, participants, employees, independent contractors or other premise owners allowing their facilities to be used for the purposes of H.O.R.S.E., and/or any and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as and/or "the Released Parties"), I hereby agree to release, indemnify, and discharge H.O.R.S.E. and the Released Parties, on behalf of myself, my children, my parents, my heirs, assigns, personal representatives and estate as follows:

1. I acknowledge that horseback riding, caring for horses, and all therapeutic activities involving horses entail known and unanticipated risks which could result in physical or emotional injury, paralysis, death, or injury to myself or third parties, or damage to property. I understand that such risks are inherent to the natural behavior of horses to act in an unpredictable manner and thus cannot be controlled or eliminated. These risks include, but are not limited to: (1) the propensity of a horse to behave in ways, i.e. running, bucking, biting, kicking, shying, stumbling, rearing, falling or stepping on, that may result in an injury, harm or death to persons on or around them; (2) the unpredictability of a horse's reaction to such things as sounds, sudden movement and unfamiliar objects, persons, or other animals; (3) certain hazards such as surface and subsurface conditions; (4) collisions with other horses or objects; and (5) the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the horse or not acting within such participant's ability."
2. I expressly agree and promise to accept and assume all of these risks, whether named or unnamed, which potentially exist in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.
3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless H.O.R.S.E., Inc., and the Released Parties, from any and all claims, demands, and/or causes of action, which are in any way connected with my participation in this activity or my use of H.O.R.S.E.'s equipment or facilities, including any such Claims which allege the negligent acts or omissions of H.O.R.S.E. and/or the Released Parties.
4. Should H.O.R.S.E. or the Released Parties be required to incur attorney's fees and costs to enforce any provision of this agreement, I agree to indemnify H.O.R.S.E. for same.
5. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else confirm my agreement to personally be responsible for all costs of such injury or damage.
6. I agree that any litigation arising out of this Agreement shall be brought solely in the state of Missouri. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.
7. I agree that I have read, reviewed and understand the State of Missouri's Equine Activity Liability Act Warning which states:

MISSOURI WARNING

UNDER MISSOURI LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO THE REVISED STATUTES OF MISSOURI, RSMO 537.325.

I understand that for the purposes of this agreement H.O.R.S.E. Inc., the Released Parties and all persons acting as agents or representatives of H.O.R.S.E. Inc. and/or the Released Parties shall be considered "equine professionals".

By signing this document, I acknowledge that if I am hurt or any of my property is damaged during my participation in this activity, I waive my right to assert any claim or bring any legal action against H.O.R.S.E. Inc. and/or the Released Parties, even for those claims allegedly involving their negligence. I have been given sufficient opportunity to read this entire document and/or to have it reviewed by legal counsel prior to my signature. I have read and understood it, and I agree to be bound by its terms.

SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE
SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE
ADDRESS OF CLIENT/PARTICIPANT(S)		
		PHONE

IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

SIGNATURE OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE



ACTIVITY AGREEMENT

Are you in need of any special accommodations to ensure you, and/or your child's or family's safety while participating in this program? If yes, please explain.

As a chosen participant in this therapeutic activity, I agree to the following as they relate to my activities at Big River Ranch and Eveningstar Equestrian Ranch or any other premises or facilities that may be used by H.O.R.S.E. from time to time:

1. I will not smoke on the property – in the barns, in any arenas or other buildings or anywhere else on the grounds. Those that accompany me understand that if they wish to do so, they may smoke in their vehicle and that no tobacco remains will be disposed of outside the vehicle on any of the properties.
 2. I will not bring any illegal substances onto the properties.
 3. I will respect our session space that includes the barns, the buildings, the grounds, the arenas and round pens located on the properties.
 4. I will be respectful of the horse owners, their horses and their property while on any of the grounds.
 5. I will not run or act in a manner that may frighten the horses that do not belong to H.O.R.S.E. and that I am not interacting with. I will not be distracting to the individuals and their horses that I encounter at the properties, knowing that to do so may endanger the safety of myself and others.
 6. I agree to follow all rules of H.O.R.S.E., Inc. and understand that my failure to follow said rules may constitute grounds for refusal of further service to me by H.O.R.S.E., Inc.
 7. Other: _____
-

✍		
SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE
✍		
SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE

IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

✍	✍	
SIGNATURE OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE



FEE AGREEMENT FORM

Dear Client/Participant:

We are committed to providing you with the best possible care. In order to achieve this goal, we need your understanding of our payment policy. Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by Brenda J. Wright or the H.O.R.S.E. agent (employee or contractor) directly involved with your therapy.

Missed appointments that are **NOT CANCELED 24 HOURS IN ADVANCE WILL BE BILLED TO YOU** and it will be your responsibility to pay for those appointment times.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges per month.

We will gladly discuss your proposed treatment with you and will try to answer any questions relating to your insurance coverage. You are also free to contact, if necessary, the individual who does our billing and discuss your billing questions with her.

Your insurance coverage is a contract between you, your employer and/or the insurance company. H.O.R.S.E. Inc., Brenda J. Wright, or H.O.R.S.E. agent(s) (employees or contractors) is not a party to that contract. Additionally, not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

As health care providers, our relationship is with you, not your insurance company. All charges are your responsibility on the date the services are rendered. We will gladly bill you for services and help you to work out a payment plan. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, PLEASE do not hesitate to ask.

Additional conditions: _____

I have read and agree to the terms of this agreement.

_____ SIGNATURE OF CLIENT/PARTICIPANT	 _____ PRINT NAME	 _____ DATE
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_____ SIGNATURE OF CLIENT/PARTICIPANT	 _____ PRINT NAME	 _____ DATE
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IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

_____ SIGNATURE OF PARENT/GUARDIAN	_____ SIGNATURE OF PARENT/GUARDIAN	 _____ DATE
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VIDEO AND PHOTOGRAPH RELEASE Consent

The below signed individuals agree to be photographed and/or videotaped by the H.O.R.S.E. program staff or volunteers while engaging in Equine Assisted Therapy and/or Equine Assisted Learning with the understanding that said media may be used by H.O.R.S.E. for the purpose of training and marketing. This includes but is not limited to, printed material, web site material, and promotional presentations. H.O.R.S.E. needs this opportunity to further the development of our mission and truly appreciates your cooperation and support by giving your consent. Thank you.

✍		
SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE
✍		
SIGNATURE OF CLIENT/PARTICIPANT	PRINT NAME	DATE

IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

✍	✍	
SIGNATURE OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE

❧ NON-CONSENT ❧

No, please do not photograph or video myself or my child.

✍		
SIGNATURE OF PARENT/GUARDIAN	PRINT NAME	DATE

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The following summary is associated with the HIPPA notice in document H.O.R.S.E. HIPPA Notice of Privacy Practices and More and is a HIPPA requirement in regard to requesting your health information and your privacy.

This notice describes how medical information about you may used and disclosed and how you can get access to this information. Please read the Notice of Privacy Practices carefully.

On this page we have summarized the document H.O.R.S.E. HIPPA Notice of Privacy Practices and More. For a complete description of your rights and our responsibilities, please review the entire notice within the above document. If you have not received this document please contact Brenda J. Wright, address and phone number listed below.

Your Rights. Your rights related to your medical information are as follows:

- The right to request restrictions on the way we use your medical information;
- The right to request and receive information from us in a different way or manner;
- The right to review your medical information;
- The right to request that we amend your medical information; and
- The right to know how we have used or disclosed your medical information.

We will not use or disclose your health information without your authorization, except as otherwise described in this Notice of Privacy Practices.

What We Are Required to Do. It is our responsibility to:

- Protect your medical information;
- Provide you with our Notice of Privacy Practices; and
- Abide by the terms of this Notice.

We can change our privacy practices. If we decide to change them, we will change this Notice and post the changes at our facility and on our website. If you have any questions and/or would like additional information, please contact the following individual:

CONTACT: Brenda J. Wright
 ADDRESS: 19021 Long Grove Rd. Higginsville, MO 64037
 PHONE: 660.584.7892

Acknowledgement. I acknowledge that I have been provided with H.O.R.S.E. HIPPA Notice of Privacy Practices and More document.

 _____
 SIGNATURE OF CLIENT/PARTICIPANT PRINT NAME DATE

 _____
 SIGNATURE OF CLIENT/PARTICIPANT PRINT NAME DATE

IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

 _____  _____ _____
 SIGNATURE OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN DATE

FOR OFFICE USE ONLY

Participant was unwilling/unable to sign Acknowledgement. Reason: _____
 Staff Initials: _____ _____
DATE