**Business Office/Mailing Address: 6480 Rockside Woods South, Suite 130 ◆ Independence, OH 44131◆ (216) 232-3656**

Client Name: _____ DOB: _____/_____/_____

## Equine Assisted Psychotherapy Informed Consent

Hope Meadows Foundation, at their contracted barns/equine centers, is providing services of Equine Assisted Psychotherapy (EAP). EAP incorporates horses experientially for emotional growth and learning. It is a collaborative effort between a mental health professional and a horse professional working with the Client(s) and horses to address treatment goals. In EAP participants learn about themselves and others by participating in activities with the horses, and then processing or discussing thoughts, beliefs, behaviors, and patterns. Horses are sensitive to non-verbal communication and respond to what messages the Clients give them in the moment. These responses give the Client and the "Treatment Team" information that brings awareness of current patterns and motivates change to new ones.

The ""Treatment Team"" is comprised of a Mental Health Professional, Equine Specialist and selected horse(s). Each Mental Health Professional is licensed by the Counselor, Social Worker and Marriage Family Therapist Board of Ohio and is interested in the overall well-being of the Client. All clinicians who are not independently licensed are under supervision and he/she will be sharing information from your session with his/her supervisor to ensure you are receiving the best care possible. You may meet or speak with a supervisor if you so desire. The Equine Specialist has proven to have experience to demonstrate being comfortable with horses and has an overall knowledge of horse communication within a herd. All selected horses are used in the therapy process during activities and have been chosen to fit the treatment goals. It is understood that all efforts will be made for you to work with the same "Treatment Team" for all your EAP sessions. If circumstances are that one member of this "Treatment Team" is unable to be part of session the Client will be notified.

**CONFIDENTIALITY:**
Information revealed by a client in the therapeutic relationship is protected from disclosure outside of the therapeutic relationship according to established legal and ethical guidelines. The EAP "Treatment Team" will not discuss or release to others any information without your specific written permission, except in the following situations: (Under such conditions you realize the Mental Health Professional of your "Treatment Team" is mandated by the laws of the State of Ohio to report such information for the safety of all concerned.)

1. If you threaten or act in a way that is very likely to harm yourself or report you have a plan or intention to harm yourself, the Mental Health Professional of your "Treatment Team" is required to notify the appropriate individual(s) or agency in order to protect you. In an emergency, where your health is in immediate danger, the Mental Health Professional of your "Treatment Team" may release information that would protect your life to another professional.

2. If you threaten serious harm to another person, the Mental Health Professional of your "Treatment Team" required to protect the other person by notifying the appropriate individual(s) or agencies.

3. If the Mental Health Professional of your "Treatment Team" believes or suspects that a child, an elderly person, a disabled person, or an animal is being abused, he/she must file a report with the appropriate county or state agency.

4. In some cases, a court of law may require the Mental Health Professional of your "Treatment Team" to testify regarding information received within the therapeutic relationship.

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5. Your "Treatment Team" may sometimes consult with other professionals about your treatment. In such cases, the "Treatment Team" would not disclose your name and other identifying information.

6. Your health insurance company may need some information about your therapy the Mental Health Professional of your "Treatment Team" will provide your diagnosis, the fee, and dates of therapy on receipts for submission to your insurance company. A treatment plan or summary of treatment may also be provided if you have authorized the release of such information with your signature on the insurance claims form.

7. The "Treatment Team" does not have a legal right to withhold from the parent or guardian information disclosed by minors under the age of 18. The "Treatment Team" will discuss with you how we prefer to handle disclosures from minors in therapy.

8. If the MH of your "Treatment Team" is under supervision, their supervisor, for your benefit, may review all aspects of your case and will maintain confidentiality except for the above listed situations.

_____Client/Parent/Guardian Initials
(indicating that you have read this policy)

**COUNSELING AGREEMENT:**

EAP/Counseling is not easily described in generalities. It varies depending on the personality of "Treatment Team" and client, problems being addressed, the "Treatment Team's" clinical judgment, the horse(s) and client goals. There are a number of approaches that can be utilized to address the problems you hope to address. It is quite different from visiting a medical doctor. EAP requires your active effort both during and between sessions in order to create meaningful change.

General benefits of EAP include, but are not limited to: relief of symptoms, increased understanding and confidence, improvement in interpersonal relationships, decreased anxiety and general improvement in daily living. EAP is experiential which allows the participant to learn about themselves and others by participating in session. Possible risks associated with EAP include, but are not limited to a temporary increase in stress due to the focus on problem areas and the possibility of dependence on the therapist. EAP also involves the use of horses, whose nature can be somewhat unpredictable. Although the "Treatment Team" will make every effort to ensure the safety of the Client, physical harm is possible due to the actions of the horses. However, no guarantees can be made regarding the outcome of your treatment.

The "Treatment Team" will be able to offer you some initial impressions of what our work may include after my evaluation (lasting 1 to 3 sessions). We will create and discuss together the initial treatment plan if you decide to continue with the process. The "Treatment Team" will work in collaboration with the Client to create goals for treatment. All activities will be conducted with these goals in mind. You should evaluate this information and your level of comfort in working with the "Treatment Team." EAP involves a large commitment of time, money, and energy, so you should be very careful in choosing a clinician. If you have any questions about our procedures, it is best to discuss them with your "treatment Team" whenever they arise. If you have doubts or are uncomfortable with our work, we will help you secure an appropriate consultation with another mental health professional.

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Please **initial** next to each of the following indicating that you have read and agreed with each:

_____ I agree to be an active participant in working toward the treatment goals my "Treatment Team" and I define together and am willing to share as I trust and feel safe.

_____ I understand that EAP/counseling is hard work, that I will need to do work in and outside of sessions in order to feel better and that there are potential risks (including but not limited to what is listed above) and benefits (including but not limited to what is listed above) to EAP/counseling.

_____ I understand no guarantees have been made to me regarding the outcome of treatment and I may choose to stop EAP/counseling at any time.

_____ I understand that I have the right to let my "Treatment Team" know if they are doing or saying something I do not like.

_____ I understand that I have the right at any point to stop EAP/counseling and/or ask for a referral.

_____ I understand my "Treatment Team" will be active listeners, trying to understand and walk alongside me, but that they cannot do the work for me.

_____ I understand that at any point if my "Treatment Team" believes that I need a different level of care, a different kind of care, if they believe there is a clinician better suited for my treatment needs and/or believe that an adjunctive service is needed at this level of care, they will tell me immediately.

_____ I consent to enter into an EAP/counseling relationship with the Hope Meadows Foundation "Treatment Team" and to play an active role in working toward the treatment goals we define together.

_____ I understand that the information I share during the counseling sessions is confidential; however, I have been advised and understand that the Law requires the Mental Health Professional of my "Treatment Team" to report certain incidents as stated above.

_____Client/Parent/Guardian Initials
(indicating that you have read this policy)

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**SESSIONS ETIQUETTE:**

1. Upon arrival, please park near the barn leaving at least one part of the circle drive open for cars to be able to leave the house. Enter the barn doors facing the driveway under the awning and wait just inside the door for your "Treatment Team."

2. EAP sessions last 53 minutes. Our time will end (unless arranged otherwise) at 7 minutes of the hour.

3. An appointment is a commitment to our work that we take very seriously. We agree to meet here and to be on time. If we are ever unable to start on time, we ask your understanding. We also assure you that if we are late you will receive the full time to which we have agreed. If you are late, we will meet for whatever amount of time remains of your scheduled appointment time.

4. Pet policy: clients are not permitted to bring their pets to therapy or on the grounds of Misty Acres of Bath LLC. The only client-owned animals permitted on the premises are properly trained service animals. "Service animals" are defined under 28 CFR 35.104, and generally include animals individually trained to do work or perform tasks for the benefit of an individual with a physical, sensory, psychiatric, intellectual, mental or other disability. One example of a service animal is a dog trained to guide the blind. "Emotional support" animals who are not properly trained service animals are not permitted.

5. It is expected that the Client will arrive on time for scheduled appointments and be prepared to spend a significant amount of time outside engaging in the therapeutic activity. This includes but is not limited to wearing close-toed footwear (**NO** sandals or flip-flops are allowed), clothing appropriate for the weather, and any other accommodation needed (i.e.; sunscreen, bug spray, hat, sunglasses, etc.).

6. The Client will be responsible for the cost of the session at the time services are given.

7. Please refer to your clinician for the barn location you are meeting at for sessions.

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**FEES:**

*Standard Individual EAP Fees*:

- ❒ $382.50 Complex Intake Session (90 minutes) with your "Treatment Team"; including horse involvement at this appointment.
- ❒ $300 Intake Session (90 minutes) with the Mental Health Professional of your "Treatment Team" ONLY; no horse involvement at this appointment.
- ❒ $200 Intake Session (53 minutes) with the Mental Health Professional of your "Treatment Team" ONLY; no horse involvement at this appointment.
- ❒ $230 for 53-minute Session which includes all costs for all of your "Treatment Team" members including the horse(s).**
- ❒ $345 for 90-minute Session which includes all costs for all of your "Treatment Team" members including the horse(s).**

*Standard Group EAP Fees:*

- ❒ $300 Group Screen/Intake for New Clients (90 minutes) with the Mental Health Professional of your "Treatment Team" ONLY; no horse involvement at this appointment. (Please Note: there is NO guarantee of acceptance to the group doing the screening)
- ❒ $200 Group Screen (53 minutes) **for existing clients ONLY** with the Mental Health Professional of your "Treatment Team" ONLY; no horse involvement at this appointment. (Please Note: there is NO guarantee of acceptance to the group doing the screening)
- ❒ $100 per Group Session (90 minutes)**

****PLEASE NOTE:** *EAP can be very powerful and effective within a few short minutes and you and your "Treatment Team" may decide that is all you can manage that day, if this happens you will be given the choice to end session early or to just spend time with the horse(s), but you will still be responsible for the full cost of your scheduled appointment.*

*Other Fees:*

- ❒ **Late Cancellation (less than 24hrs notice) and/or No-Show**
  - **Full Cost of the scheduled session** (as listed above)
- ❒ **Professional Time (may include but is not limited to):** phone calls, consultation, report writing, form completion, and letter writing.
  - $120 per hour (prorated at $2.00/minute)

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- ❒ **Unscheduled or After-Hours Rate:**
  - $270/hour (prorated at $4.50/minute)
- ❒ **Legal Involvement** (includes preparation for and attendance at any legal proceedings)**:**
  - $300 per hour (due to complexity and difficulty of legal involvement)
- ❒ **Out-of-office work** (e.g., in-home consultation/visits)**:**
  - **$200 per hour "portal to portal"** (meaning that you will be billed for the time we are out of the office on your behalf).

**Please Note: <u>All fees are to be paid at the time of service.</u>**

_____Client/Parent/Guardian Initials
(indicating that you have read this policy)

**PAYMENT POLICY:**

In order to remain on time for others and make the most of your time in session, it is helpful if you have your payment ready (i.e., check written, exact cash, credit card) prior to the beginning of session.

*<u>Accepted payment types:</u>*

We accept Cash, check, and all major credit cards.

Insurance and Paperwork:

- ❒ Clients are responsible for handling payment from insurance companies. Your insurance coverage is a contract between you and your insurance provider. We are not a part of that arrangement/contract. We will most likely be considered an out-of-network provider; you will need to inquire as to your benefits in light of this fact. Most insurance companies do not cover EAP (equine assisted psychotherapy).

- ❒ We will give you a receipt at your request that contains all the information needed if you plan on submitting your receipt for reimbursement.

- ❒ **By initialing (Client/Parent/Guardian) here: _____** ***(optional)*** You are stating that you give Hope Meadows Foundation and it's Staff/"Treatment Team" permission to store your credit card information on our electronic medical records system, and for Hope Meadows Foundation and it's Staff/"Treatment Team" to use this credit card information to charge for sessions and/or other fees as listed above when no other form of payment is given or set in place at the time of any service/Late Cancellation/No-Show. By initialing you are stating that you are releasing Hope Meadows Foundation and it's Staff/"Treatment Team" from any legal responsibility if a breach were to occur on your card from storing this form of payment.

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**CANCELLATION POLICY**

- ❒ Once an appointment is scheduled, you will be expected to pay for it unless you provide notice 24 hours in advance of the appointment time.

- ❒ If you miss an appointment without notifying us or cancel with less than 24-hour notice, you are responsible for the full fee for that appointment. Please note that insurance companies do not reimburse for missed appointments.

_____Client/Parent/Guardian Initials
(indicating that you have read this policy)

**BUSINESS HOURS / PHONE CALLS AND MESSAGES**

- ❒ We are often not immediately available by phone. We do not answer the phone when we are with clients. Office hours are limited at this time but can schedule availability for professional time Monday through Friday from 9am to 5pm. Any professional time (except appointment arrangement) spent outside of these hours is considered after- hours unless previously negotiated.

- ❒ We strive to return phone calls promptly but there can be unavoidable delays. If we are unavailable for a period of several days (e.g., workshops, seminars, vacations, illness) we will leave instructions on the telephone message regarding alternative contacts.

_____Client/Parent/Guardian Initials
(indicating that you have read this policy)

**EMERGENCY POLICY:** ***PLEASE NOTE: WE <u>DO NOT</u> have 24/7 emergency services***

- ❒ We believe in the inherent strength and capabilities of our clients. We strive to foster stability and healthy use of resources. We do not therefore carry a pager and are not available 24/7. If this is not consistent with your needs or expectations please consult with your "Treatment Team" so that they may provide you with an appropriate referral.

- ❒ In the event of life and death emergency (or other instances when we may be unavailable) you will need to have alternate sources of help including but not limited to the following:

  - ○ 911
  - ○ Clergy
  - ○ Local Hospital
  - ○ Mental Health Crisis Lines
  - ○ Community Mental Health Center
  - ○ Social Support Network (e.g., family, friends, coworkers)

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**ELECTRONIC COMMUNICATION POLICY:**

Because of the importance of your confidentiality as a client, we keep communication via electronic devices/internet to a minimum. We communicate almost exclusively by voice (phone/voicemail). Text communication via cell/smart phones and the internet/email has inherent risks that include but are not limited to the following: breaches of confidentiality, theft of personal information, your service storing emails unprotected, and disruption of service due to technical difficulties. For these reasons, we keep the following policies:

1. WE DO NOT communicate professionally via text (cell/smart phone).

2. When phone communication is not possible email may be used to share information about scheduling appointments. Please CALL US when scheduling/cancelling appointments. Email may be used as a backup to voicemail but please do not use it as the primary means of communicating appointment changes (particularly if less than 24-hour notice).

3. No information regarding therapeutic issues will be handled by email.

4. We do, at times, provide supplemental information and materials including but not limited to educational materials, links to educational sites/resources, forms, and homework sheets via email but only with your permission by initials below.

5. It is strongly advised that you NOT use a work email address for any communication as many employers monitor employees' electronic communications.

6. It is your responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

7. If you do not want to be contacted via email it is your responsibility to indicate this on your client Intake Form.

By initialing (Client/Parent/Guardian) here: _____ *(optional)* You are stating that you have read the above policies, understand them, and agree to take on the inherent risks (including but not limited what is listed above) of using electronic communication when sending and receiving electronic communication from Hope Meadows Foundation and it's Staff/"Treatment Team" and understand that neither Hope Meadows Foundation nor it's Staff/"Treatment Team" can guarantee confidentiality, even with encrypted electronic communication, if electronic communication is used and by initialing you are stating that you are releasing Hope Meadows Foundation and it's Staff/"Treatment Team" from any legal responsibility if a breach were to occur using this form of communication.

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**NOTICE OF TERMINATION POLICY:**

- ❒ You are not obligated to see me for any specified number of sessions. It is most beneficial to you, however; to have a healthful ending to a therapeutic relationship. The process of ending therapy, called "termination," can be a very valuable part of our work.

- ❒ Stopping therapy should not be done casually. If you wish to stop therapy at any time, we ask that you agree now to meet then for at least one session to review our work together. This will allow us to discuss critical issues and reasons for termination and bring the relationship to a more beneficial ending.

- ❒ Please note that the policy will be to terminate your file from my case load upon a closure session or upon 3 months after your last session whichever comes first and this Informed Consent services as your notice of termination if the latter occurs.

- ❒ If in the future you wish to return for services, we would be more than happy to discuss re-opening your case if we are able to at that time; if we are unable to at that time we would be happy to provide referrals. Please note that if it has been longer than 6 months since your last session you will need to resign and update your forms and if it has been longer than a year we will need to do a new Intake session (see fees for details).

_____Client/Parent/Guardian Initials
(indicating that you have read this policy)

**OTHER POLICIES:**

I understand that learning the Principles in EAP does not permit me to use these techniques by myself with horses or with Clients/family/friends/self/etc, unless I have gone through the trainings or certifications myself. I understand that the goal of learning these Principles is to help me improve my relationships with other people and not to teach these Principles to Clients/family/friends/self/etc, or to use with horses, unless I have gone through the necessary trainings or certifications. I also understand that the EAP experience at Hope Meadows Foundation, at their contracted barns/equine centers, is NOT a sufficient EAP certification/training that qualifies me to teach these principles to others or to use with horses.

If I wish to teach/train/copy these Principles to others or use with horses I understand that I must first go to the Natural Lifemanship training/certification process or through the EAGALA certification process or another qualified training program. I understand this then means I cannot copy the materials provided to me by Hope Meadows Foundation, at their contracted barns/equine centers, without permission first from the copyright owner.

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Under Ohio law, an equine activity sponsor, equine activity participant, equine professional, veterinarian, farrier, or other person is not liable in damages in a tort or other civil action for harm that an equine activity participant allegedly sustains during an equine activity and that results from an inherent risk of an equine activity, pursuant to Ohio Revised Code Annotated § 2305.321 (2001).

_____Client/Parent/Guardian Initials
(indicating that you have read this policy)

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship:

Today's Date: _____Client's DOB:_____

Client Signature:_____

Client's Printed Name:_____

Parent's Signature:_____

Parent's Printed Name:_____

EAP Clinician Signature:_____

EAP Clinician Printed Name:_____

- ❑ **Ph.D.** ❑ **Licensed Professional Clinical Counselor** ❑ **Intern/CT**
- ❑ **Psy.D.** ❑ **License Professional Counselor** ❑ **License Independent Social Worker**
- ❑ **Licensed Social Worker** ❑ **Other:** _____

**Supervisor's Signature:** (when applicable) _____ **Date:** _____

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