

Healing Hoofbeats, LLC

Registration Form for Therapeutic Mentoring

Start Date: _____

End Date: _____

Child's Legal Name: _____ Child's Preferred Name: _____

Gender: _____ Date of Birth: _____ Age: _____ Grade: _____ School: _____

Parent/Guardian name: _____

Address: _____

Phone #'s: (Home) _____ (Work) _____ (Cell) _____

E-mail address: _____

DCF Involvement? Y N Area Office & Worker Name/Number: _____

Emergency contact (Other than parent/guardian):

Name: _____

Relation to participant: _____

Phone #'s: (H) _____ (W) _____ (C) _____

Does your child have any mental health diagnoses?

What goals do you have for your child with which we can help? In other words, what are some areas of improvement?

Circle all that your child would enjoy participating in while with his/her mentor:

Caring for horses/animals

Working with horses

Physical activities

Vegetable and flower gardens

Arts & crafts

Working with other animals

Please explain if there are any situations that may cause your child difficulty: _____

How can we best work with you to help your child in these situations? _____

What are some things you think are important to know about your child?

If/when your child acts out, what does that look like? What behaviors do you see?

What are some things your child enjoys doing (hobbies, sports, music, interests, etc)

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What typically helps calm your child down when upset, sad, dysregulated, frustrated, angry, or not feeling well?

Does your child exhibit any of these behaviors/concerns?

Circle and describe applicable issues (indicate current or history of):

Inattention
Hyperactivity
Lack of concentration
Learning disabilities
Developmentally delayed
Mentally challenged
Boundary issues
Social skills problems
Problems with peers
Separation anxiety
Anxiety
Phobias
Aggressive
Assaultive
Manipulative
Unpredictable or dangerous behavior
Sensory impairment
Sensitivity, preferences

Tics or stereotypical behavior
Psychosomatic behavior
Suicidal ideations
History of runaway
Issues of parental support
Sexual abuse/acting out
History of physical abuse
Emotional abuse
Hallucinations
Delusions
Illusions
Dissociations
Substance abuse problems
Legal problems
School problems
History of animal abuse and/or fire setting
Seizure disorder
Possible medication side effect

Additional Comments:

INFORMED CONSENT TO TREAT

In order to provide you with the best possible care, the following policies have been outlined for you. Read them carefully, and feel free to make a copy for yourself. Please sign below indicating your acknowledgement of the information and acceptance of the terms for treatment.

CONFIDENTIALITY

Any information that you provide, or records we maintain, are kept strictly confidential, and comply with HIPAA regulations. Treatment progress is shared with providers and involved members via treatment planning.

SAFETY

Safety for clients, staff, horses, volunteers, and anyone is of primary concern, and Healing Hoofbeats, LLC is committed to operating in a manner which is consistent with that concern. Consequently, the programs, facility, horses & other animals, equipment, etc. meet industry standards, and employees have extensive horse/animal knowledge. Nonetheless, there are limits inherent in any animal assisted program.

EMERGENCIES

Physical emergencies will be handled according to information on the Authorization for Emergency Medical Treatment form. Psychological emergencies should be handled with the therapist and if further assistance is needed Emergency Services may be called. Steps taken in a psychological emergency is at the discretion of the clinical social worker.

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LIABILITY RELEASE AGREEMENT AND CONSENT TO TREAT

I, _____ (PARENT/GUARDIAN NAME) would like my child and/or myself to participate in therapeutic services at Healing Hoofbeats, LLC. I acknowledge the risks and potential for risks of equine & animal assisted activities. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Healing Hoofbeats, LLC and its employees/interns for any and all injuries and/or losses I/my child/my ward may sustain while participating in equine & animal assisted activities or therapies at the program.

Client/Guardian Signature

Date

PHOTO RELEASE

I **do/not** (circle one) consent to and authorize the use and reproduction by Healing Hoofbeats, LLC of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Client/Guardian Signature

Date

CANCELLATION POLICY

I, _____, agree to notify Healing Hoofbeats, LLC of any cancellation needs prior to 24 hours of the scheduled appointment. If cancellation occurs prior to 24 hours of my appointment I will not be charged. If a cancellation occurs within less than 24 hours, I understand that I will be charged the full fee amount and must be paid prior to the next session. I also understand that not showing for a scheduled appointment is considered a cancellation and will be charged the full amount for my session.

Client/Guardian Signature

Date

FEE SCHEDULE

The following describes the fees for various services. Should you be utilizing your insurance, please look to your policy to understand if there are co-pays attached. If you are paying out of pocket and wish to be reimbursed by your insurance company Healing Hoofbeats, LLC can provide a superbill for submission to your insurance company. Healing Hoofbeats, LLC reserves the right to change the fee for services at any time, giving clients at least 2 months notice.

Individual Therapy: \$120/hour

Couples Therapy: \$130/hour

Family Therapy: \$160/hour

Group Therapy: \$45/hour

Therapeutic Mentoring: \$50/hour

Supervised Visitation: \$55/hour