**Client Name: _____**

# 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. Exclusions that specifically apply to the equine assisted psychotherapy:

- Any other therapeutic riding instructors, volunteers, interns, or staff may need limited client information in order to provide for therapeutic effectiveness and/or safety. Any staff or volunteers are trained and supervised regarding confidentiality.

**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.

**AVAILABILITY/HOURS OF OPERATION**

Healing Hoofbeats of CT, Inc. is open Monday -Friday from 9a-6p; however, each therapist's schedule and availability varies. Therapists will return calls and emails from clients within a reasonable timeframe of no more than 1 business day for routine calls and no more than 4 hours for emergency calls. Therapists are not available outside of regular business hours and will respond to correspondence the next business day.

_____

Client Signature Date

_____

Guardian Signature Date

**LIABILITY RELEASE AGREEMENT AND CONSENT TO TREAT**

I, _____ (CLIENT NAME) would like to participate in equine assisted psychotherapy. I acknowledge the risks and potential for risks of equine 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 of CT, Inc., it's employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in equine assisted activities or therapies at the program.

**************Signature of legally responsible party must be witnessed******************

_____

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 of CT, Inc. can provide a superbill for submission to your insurance company. Healing Hoofbeats of CT, Inc. reserves the right to change the fee for services at any time, giving clients at least 2 months notice.

Individual Therapy: $200/hour
Couples Therapy: $220/hour
Family Therapy: $240/hour
Virtual Group Therapy: $30/hour

**CANCELATION POLICY**

I, _____, agree to notify Healing Hoofbeats of CT, Inc. 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 session 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. Two no-show appointments will result in possible loss of regular weekly time slot or termination of services.

_____

Client Signature Date

_____

Guardian Signature Date

**CONSENT FOR TELEMENTAL HEALTH SERVICES**

**WHAT IS TELEMENTAL HEALTHCARE?**

Telemental health is a subset of telehealth services that uses online, interactive videoconference software to provide mental health services from a distance. Telemental health includes terms such as telepsychology, telebehavioral health, online counseling, and distance counseling. Private insurance companies in CT, NY, and many other states are required by law to cover telemental health services. Telehealth does not include the use of fax, audio-only telephone, e-mail, or videotelephony products such as FaceTime and Skype.

**SOME POTENTIAL RISKS OF TELEMENTAL HEALTH**

- Technological failures such as unclear video, loss of sound, poor internet connection, or loss of internet connection
- Nonverbal cues might be more difficult to observe and interpret during therapist and client interactions
- Must electronically share and sign practice and consent forms and accept risks that come with transmitting information and documents over the internet

**BENEFITS OF TELEMENTAL HEALTH**

- Less limited by geographical location and transportation concerns
- Decrease in travel time and ability to meet virtually during inclement weather conditions
- Ability to participate in treatment from your own home or other environment where you feel safe, secure, and comfortable

**ELIGIBILITY**

Healing Hoofbeats of CT, Inc. is only able to provide telemental health services to clients located in Connecticut where our therapists hold valid licenses as mental health professionals. Clients must present a valid ID during the initial consultation

and provide a copy for the medical file. Telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit better from another form of service (e.g. face-to-face sessions) or another provider, an appropriate recommendation will be made.

**PRIVACY AND CONFIDENTIALITY**

The current laws that protect privacy and confidentiality also apply to telemental health services. Exceptions to confidentiality are described in the Notice of Privacy Practices. All existing laws regarding client access to mental health information and copies of mental health records apply. Telemental health services are provided through the HIPAA compliant, secure software via Doxy.me. No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store video from sessions.

**CLIENT EXPECTATIONS DURING TELEMENTAL HEALTH SESSIONS**

- Mac/PC/Chromebook, smart phone, or tablet with camera, microphone, and speakers
- Internet connection with at least 750kb/s download and upload speeds
- Access to Google Chrome or Mozilla Firefox (latest release versions) web browsers
- Proper lighting and seating to ensure a clear image of each party's face
- Dress and environment appropriate to an in-office visit
- Engage in sessions in a private location where you cannot be heard by others
- Only agreed upon participants will be present; the presence of individuals unapproved by both parties will be cause for termination of the session
- Client must disclose the physical address of their location at the start of the session; unknown locations will be cause for termination of the session
- Client shall provide a phone number where they can be reached in the event of service disruption

**EMERGENCY PROTOCOL**

Client is to provide the name and contact information for a local emergency contact. In the case of a mental health emergency during a telemental health session where a client is at imminent risk of harming themselves or someone else, therapist will contact the client's local emergency services. The contact information for the client's nearest emergency room will also be on record. Release of Information forms will be completed for necessary entities unless confidentiality must be breached to protect the safety of the client or another identified individual.

**PAYMENT PROCEDURES**

Client must pay for telemental health services using a credit card if it is not covered by client's insurance. The credit card placed on file will be charged following each telemental health session. It is up to the client to notify the therapist before the end of the session if he/she wishes to use a different credit card for payment or change the credit card on file.

**CONSENT FOR TELEMENTAL HEALTH TREATMENT**

I hereby consent to engage in telemental health services with Healing Hoofbeats of CT, Inc. I understand that telemental health includes mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical and mental health information. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

_____ _____

Client/Guardian Signature Printed Name of Client/Guardian

_____

Date

**Credit Card Authorization Agreement**

**Please complete the following form. This form will be securely stored in your clinical file and may be updated upon request at any time.** In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

I, _____, authorize Healing Hoofbeats of CT, Inc. to use my credit card information to charge my credit card via Square in the event that I do not notify my therapist of my inability to attend my scheduled therapy session and/or do not cancel my appointment with at least 24 hours notice, or if a check is returned for any reason. I will not discharge charges ("charge back") for sessions I have received or appointments I have missed according to the above policy. If I fail to provide payment within 30 days of the billing date, I authorize that Healing Hoofbeats of CT, Inc. can use my credit card information to charge my credit card via Square to pay off my account balance.

Card Type (circle one): VISA MASTERCARD DISCOVER AMEX

Name as it appears on Card: _____

Card Number: _____ Exp. Date: _____ CVC: _____

Billing Address: _____
City: _____ State: _____ Zip: _____

By signing below I am authorizing Healing Hoofbeats of CT, Inc. to charge my credit card for missed or unpaid scheduled sessions.

_____
Signature Date