



horse sense business sense



PRACTICAL TOOLS FOR BUILDING A SUCCESSFUL EQUINE ASSISTED PROGRAM

Horse Sense, Business Sense: Forms & Paperwork

Shannon Knapp
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horsesenseotc.com

Praise for *Horse Sense, Business Sense* and Shannon Knapp

"Until you start to dig around, a new equine facilitated business doesn't necessarily have a place to begin. This book will be the new start-up Bible for my development as an equine practitioner and entrepreneur. I've had quite a bit put into perspective for me, and you've got me all determined and thoughtful about the possibilities. I am not discouraged; I feel more empowered!"

Robin Brosmer, *EAGALA Level I*, Orlando FL

"I wish I'd had something this useful back when S.T.A.R.S. was started. Even now it would be of tremendous help for our board and the instructors to read this. This is a good time in the history of therapeutic riding and psychotherapeutic programs for [this information] to be presented. I think the industry will be thankful to have such a thorough resource available."

Sue Wheeler, Founder, *S.T.A.R.S. Program*, Iowa

"Thanks for being the dedicated individual you are and 'taking the time it takes' to educate the rest of us so that this growing discipline can be something that will significantly impact horses and people in a positive way."

Lisa Martin, *Kingdom Equus Equine Assisted Programs*, Alabama

"Shannon is very accommodating and shows an honest interest in helping this business . . . she is eager to share the work she has done to save others time and frustration."

Vikki J. Paese, *Horses Helping Humans*, SC

"I would say if you are interested in starting your own EAP/EAL business and need advice . . . she is the best."

Tracy P. Setzler, MPH, MSW, *Family Connection of South Carolina*

"Many times I feel like this colt, young and inexperienced in my equine business. I thank God for people like [Shannon] willing to help others on their journey."

Meloney Nunez, *Healing Reigns*, Arizona

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Ready to **Make a Difference?**

Horse Sense offers a variety of resources that help you be successful in your EAP/EAL business. Visit our website for more information and details about how you can get extra support! Visit www.HorseSenseOtc.com and learn more about . . .

Free Information, Free Telecalls, Free Reports, and More!

- ◆ Our monthly newsletter, free monthly telecalls, our blog and other items, keeping you informed about key issues and exciting, important developments in the field

Consultations

- ◆ Individualized, 1 on 1 consultation, Consultation packages, and Project consultation programs to help you with specific goals

Programs

- ◆ Telecalls, Teleclasses, and Onsite Workshops, both day-long and multi-day events

Products

- ◆ Activity Guidebooks and Program Journals from existing *Horse Sense* groups.
Upcoming: Audio CD's and CD packages on a range of topics to help you succeed, and Step-by-Step Workbook Companions to guide your way

Shannon is dedicated to the success of the field, and to your success as a provider of services. The more quality EAP/EAL programs, the more people know about our work, the more clients benefit, and the more we work together to improve the lives of horses and humans everywhere. We are not competitors! The more of us out there doing this, and most importantly doing it *well*, simply raises the profile of our profession, from which we all benefit.

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Dear Reader,

Thank you for purchasing Horse Sense, Business Sense: Forms & Paperwork. We are delighted to take the struggle and effort out of this aspect of your Equine Assisted Therapy & Learning business. We've been modifying, correcting and changing our paperwork since inception, and what you have in front of you now represents the most recent revision as of September 2007.

Some of the changes since our last version (in March 2007) include the addition of the "Abbreviated Assessment" for when we are working with clients from an inpatient facility, a facility that is already doing a full assessment. However since we are also providing services, we still need to have our own assessment of each client, albeit brief. We've also made changes (small but important, we've found), to our Referral Form, the Medical History sheet, the Session Notes sheet and our Notice of Privacy Practices forms. The Equine Liability form now also includes a Confidentiality Agreement, whereas before these were two separate documents. We've added our "Consent for Data to be used in Research Studies", and, most importantly, we have stopped billing using interactive codes and are now billing what we call "straight codes". We recently ran across a memo that outlined what constituted "interactive", and we do not feel Equine Psychotherapy meets that criteria.

Thanks for your dedication to the field, and if you have any questions, please don't hesitate to contact us at info@HorseSenseOtc.com. Also know that our new Policies and Procedures Handbook is now available for purchase, the cost of which includes a one-hour consultation with Lisa Wheeler, our practice administrator at Horse Sense. To learn more about this and about other Horse Sense solutions for EAP/EAL businesses, visit www.HorseSenseOtc.com. Check out all the opportunities to gain valuable information through free Telecalls, Teleclasses, consulting packages, onsite and off site workshops, and much more.

Thanks so much for your interest in this wonderful field, and for bringing this service to your community. Please let us know how we can support you in your endeavors.

All the best,



Shannon Knapp, Founder and President
Horse Sense of the Carolinas, Inc.

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Horse Sense of the Carolinas, Inc.
Phone Screening / Referral Form

Answered by _____ Date _____

Appointment scheduled for: _____ with _____

Client Name: _____ Age: _____ D.O.B: _____ SS# _____ M / F

Address: _____ City & State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Message OK? Y / N

Caller Name: _____ Relationship to Client: _____

Legal Guardian: (must sign all paperwork) _____

Legal Guardian phone numbers: H _____ W _____ C _____

Reasons seeking therapy: _____

Previous Treatment? _____ Provider: _____

Existing Diagnoses? _____

Psychiatric Hospitalization in past year? _____

Legal Involvement: _____ On probation? Y / N

Medications: _____

Prescribed by: _____ Current Therapist: _____

Medical Issues we should know about: _____

Referring Organization / Contact Person _____ How hear of HS? _____

Medicaid Carolina Access Medicaid Health Choice Self-Pay / Private Ins. (pay at time of service)

Grant **Must have below info if billing Carolina Access Medicaid**

Full name of Primary Care Physician if Medicaid: _____

Carolina Access # for Primary Care Physician if Carolina Access Medicaid: _____

Name of Primary Care Practice _____ Phone # _____

Address: _____

Complete diagnosis and copy for front desk after full evaluation is completed if billing Medicaid/Health Choice

Axis I: code _____

I: code _____

Axis II: code _____ Axis III _____



Referral Form

Form must be **fully** completed and approved by HSOTC **before** client's appointment. **Medicaid** clients must have copy of Medicaid card accompany this form. Medicaid clients that are **Carolina Access Enrollees** must include their Primary Care Physicians Carolina Access Number. Client is not eligible for Medicaid coverage if any part of this form is left blank.

Client Name: _____

Preferred Name: _____ Date of Birth: _____ Present Age: _____

Street Address: _____ City and State: _____ Zip Code: _____

Billing Address (if different): _____

Name(s) of Parent / Legal Guardian: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Presenting Issues: _____

Diagnosis: Axis I: _____ Code: _____

(cannot leave blank) Axis II: _____ Code: _____

Axis III: _____ Code: _____

Desire to Change (circle one): good fair poor

Ability to Change (circle one): good fair poor

Support Systems: _____

Medications: _____

Side Effects: _____

If Client is Carolina Access Enrollee – Carolina Access Number (7-digit number): _____

Primary Care Physician: _____ **Phone:** _____

Name of referring licensed professional: _____ Relationship to client: _____

Referring Organization: _____

Street Address: _____ City & State: _____ Zip Code: _____

Work Phone: _____ Cell Phone: _____ Fax: _____

E-Mail: _____ Best Times to Contact: _____

Signature: _____ Date: _____

****Please attach copy of current Medicaid card with this form****



Registration

Client Name _____

Legal Guardian Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone # _____ Pager # _____

Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Gender [] Male [] Female

Employer or School _____ Employment Status _____

Referred by _____

[] Medicaid [] Health Choice [] Self-Pay (pay at time of service)

[] Private Insurance (pay at time of service—client files own claim) [] Grant funded

*****Please attach copy of current Medicaid or Health Choice card***
MUST bring current Medicaid card to EACH session, or rescheduled**

If you have (Carolina Access) Medicaid, the following information must be provided before the initial evaluation appointment:

1. Copy of current Medicaid card
2. Primary Care Physician *full* name _____
3. *Carolina Access* # of Primary Care Physician _____
4. Primary Care Physician's Practice Name. _____

I, _____ (name of adult client or guardian of minor client) agree to pay *Horse Sense of the Carolinas, Inc* at the current rate for the services provided to me (or the client named above for whom I have legal responsibility). I understand that I am responsible for these charges and that fees are due at the time service is provided, unless I make arrangements in advance. If grant-funded, these policies only apply to late cancellation/missed appointment fees.

Client's Signature (or parent/guardian/responsible party)

Witness Signature

Date

Date



Horse Sense of the Carolinas, Inc.

Abbreviated Assessment

Client Name: _____

DOB: _____

DATE OF ABBREVIATED ASSESSMENT: _____

Abbreviated Assessment serves as an addendum to the primary assessment (attached) completed by client's primary treatment provider listed below:

Primary Treatment Provider/Agency

Date of Primary Assessment

LEGAL GUARDIAN No change from previous Assessment
 Self Other

PRESENTING PROBLEM

- Client presents with substantially the same symptoms since time of primary assessment
 Client presents with worsened symptoms or significantly changed treatment needs since the time of the primary assessment; describe: _____

SOCIAL/EMPLOYMENT/EDUCATIONAL/FINANCIAL CHANGES SINCE LAST VISIT?

- No change from previous assessment
 Significant changes from previous assessment; describe: _____

MENTAL STATUS:

Mood: appropriate to situation euthymic depressed sad anxious irritable manic
 euphoric other _____

Affect: appropriate flat labile tearful other _____

Thought content: appropriate to situation paranoia delusions preoccupation other _____

Thought process: normal slow circumstantial blocking tangential flight of ideas other _____

Hallucinations: none auditory visual olfactory tactile gustatory

Orientation: Person yes no Place yes no Time yes no Situation yes no

Judgment: appropriate for age limited poor

Attention: good fair poor

Insight: age appropriate limited poor

Motor activity: appropriate for age agitated/hyperactive hypoactive

1 of 2 Abbreviated Assessment

Risk Assessment:

Potential Danger to Self Yes No Based on Current behaviors or history explain:

If yes, Suicidal Ideation Yes No

If yes, Plan Yes No

Self Mutilation Yes No

If plan, describe plan/lethality/risk factors:

Does client/guardian report access to lethal means of self injury? Yes No Details:

Does client/guardian report ability/support system to maintain safety? Yes No

Potential Danger to Others Yes No Based on Current behaviors or history explain:

If yes, homicidal Ideation Yes No

If yes, Plan Yes No

Self Mutilation Yes No

If plan, describe plan/lethality/risk factors:

Does client/guardian report access to lethal means of harming others? Yes No Details:

Does client/guardian report ability/support system to maintain safety? Yes No

DIAGNOSES:

Agree with Diagnoses Obtained from Previous Assessment: Yes No (Provide New Diagnoses Or Revisions Below)

Axis I:

Axis II:

Axis III:

Axis IV:

Disposition: _____ Appropriate for treatment at Horse Sense of the Carolinas, Inc.

_____ Agree with goals listed in Treatment Plan, dated _____ provided by referring agency (see attached primary Treatment Plan listing client goals to be addressed via Horse Sense of the Carolinas, Inc.)

_____ Not appropriate for treatment at Horse Sense of the Carolinas, Inc. due to the blow reasons:

Alternative Recommendations Offered: _____

Clinician

Date

Persons Living in Home / Family Relationships (Genogram):

School / Social / Work History: _____

Strengths/Resources (support system / community resources): _____

Previous Counseling or Meds -- (positive or negative experience): _____

Current Medications: _____

Medical Issues: _____

History of Abuse (physical, sexual, emotional, neglect)---DSS?: _____

Family Mental Health / Substance Abuse History:

Paternal: _____

Maternal: _____

Substance Abuse History: _____

DRUG	FIRST USE	CURRENT USE FREQ/AMNT	LAST USE	TOLERANCE
ALCOHOL				<input type="checkbox"/> yes <input type="checkbox"/> no
MARIJUANA				<input type="checkbox"/> yes <input type="checkbox"/> no
COCAINE				<input type="checkbox"/> yes <input type="checkbox"/> no
STIMULANTS				<input type="checkbox"/> yes <input type="checkbox"/> no
HALLUCINOGENS				<input type="checkbox"/> yes <input type="checkbox"/> no
HEROIN				<input type="checkbox"/> yes <input type="checkbox"/> no
INHALANTS				<input type="checkbox"/> yes <input type="checkbox"/> no
OTHER _____				<input type="checkbox"/> yes <input type="checkbox"/> no

Physical problems associated with drug use: _____

Family history of substance abuse: _____

Previous substance abuse treatment: _____

Response to Treatment: _____

Support groups: AA NA Has sponsor Attends Meetings Family Friends Other

Legal: _____

Mental Status : Mood: _____ appropriate to situation, _____
Affect: _____ appropriate to situation, _____ Judgment: _____ age appropriate, _____
Speech: _____ logical/ goal oriented, _____ Insight: _____ age appropriate, _____
Thought Content/Process: _____ normal, _____ Orientation: _____ x 4, _____
Motor activity: _____ unremarkable, _____ Comments; _____

-SI past/present: _____

-Self –mutilation: _____

-H/I Aggression Past/present: _____

Problems with:

-Sleep: _____ Encopresis / Enuresis _____

-Appetite / weight changes: _____

-Energy/Motivation/Self Care: _____

Formulation / Diagnostic Impression: _____

AXIS:

I _____

II _____

III _____

IV _____

V _____

Initial Treatment Recommendations: _____

Signature: _____ **Date:** _____



**Horse Sense of the Carolinas, Inc.
 Medical History, Emergency Information, & Health Care Consent**

Client's Full Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

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

Height: _____ Weight: _____ Tetanus Shot: Y[] N[]

Medications & Dosage	Taken Since	Prescribed by (Physician)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any areas of medical concern. If "yes," please explain in the Comments section

Areas	Yes	No	Comments
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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

By signing this form, I, _____ (please print parent/guardian/ adult client name) certify all information to be complete and true to the best of my knowledge.

Client's Signature: _____ Date: _____

Parent/Guardian's Signature (If client is minor): _____ Date: _____

Horse Sense of the Carolinas, Inc.
Medical History, Emergency Information, & Health Care Consent

Parent/Guardian _____ Phone Numbers _____

*1st Emergency Contact _____ Relationship to Client _____ Phone _____

*2nd Emergency Contact _____ Relationship to Client _____ Phone _____

(*client's or parent/guardian's first choice for us to call if parent/guardian is unavailable in a medical emergency)

Patient's Primary Physician _____ Phone Number _____

Preferred Medical Facility: _____

Emergency Medical Consent

The undersigned hereby grants to any *Horse Sense of the Carolinas Inc.* affiliate/employee/intern/volunteer the authority to receive information pertaining to the emergency health care of the client named below and to make emergency health care decisions with respect to the client if the undersigned is unavailable to obtain such information or make such decisions.

Client's Name _____ Phone: _____

Address: _____

Date: _____ Signature: _____
(parent, guardian, or adult client)

+++++

Emergency Medical Non-Consent

If the undersigned does not desire to grant any *Horse Sense of the Carolinas, Inc* affiliate/employee/intern/volunteer information or to make health care decisions for the client if the undersigned is unavailable, please initial on the line below and state 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 any *Horse Sense of the Carolinas, Inc.* affiliate/employee/intern/volunteer obtaining health care information or making emergency health care decisions concerning the client.

Procedures to be followed: _____

Date: _____ Signature: _____
(parent, guardian, or adult client)



Consent Release of Information

Client's Name: _____ Date of Birth: _____ Age: _____
 Parent/Guardian Name: _____

I hereby authorize *Horse Sense of the Carolinas, Inc.* to release and/or exchange protected health information for the above stated client for the duration of services received from *Horse Sense of the Carolinas, Inc.* with:

Name of Applicable Professional: _____
 Organization: _____
 Street Address: _____
 City & State: _____ Zip Code: _____
 Office Phone: _____ Fax Phone: _____

The protected information to be released and/or exchanged include:

- | | | |
|--|---|--|
| <input type="checkbox"/> Admission Assessment | <input type="checkbox"/> Substance Abuse Info | <input type="checkbox"/> Mental Status |
| <input type="checkbox"/> Evaluation | <input type="checkbox"/> Discharge Plan | <input type="checkbox"/> Diagnoses |
| <input type="checkbox"/> Treatment Plan(s) | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Psychological Records |
| <input type="checkbox"/> Court/Agency Documents | <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Educational Records |
| <input type="checkbox"/> Other (please explain): _____ | | |

Purpose of Contract: This form implements the requirements for client authorization/consent to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), and state confidentiality law governing mental health, development disabilities, and substance abuse services (G.S. 122C).

Redisclosure: Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S.122C) or substance abuse treatment information protected by federal law (42C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

Revocation and Expiration: I understand that, with certain exceptions, I have the right to revoke this authorization at any time. (If I want to revoke this authorization, I must do so in writing.) If not revoked earlier, this authorization expires automatically upon _____ (Date or event that related to the client or the purpose of the use or disclosure) when treatment episode ends or one year from the date it is signed, whichever is earlier. **Notice of Voluntariness:** I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that *Horse Sense of the Carolinas, Inc.*, will not deny or refuse treatment because of my refusal to sign.

 Signature of Client or Legal Guardian*

 Date

 *Relationship of Legal Guardian to client

(next page)



Horse Sense of the Carolinas, Inc. Confidentiality Agreement and equine Activity Liability Release And Risk Acknowledgement

Confidentiality Agreement

By signing below, I agree not to disclose any client names, treatment information or identifying information pertaining to any client, past, present or future, of *Horse Sense of The Carolinas, Inc.* to anyone who is not affiliated with *Horse Sense of The Carolinas, Inc.* This confidentiality agreement is effective the date of the signing of this agreement, and is forever binding after my association with *Horse Sense of The Carolinas, Inc.* ends.

Equine Liability Release and Risk Acknowledgement:

1. **Parties.** The parties to this document are Horse Sense of the Carolinas, Inc (hereinafter "Horse Sense") and _____ (hereinafter "client").
(print client name here)

2. **Apportionment of Liability.** In consideration of client being allowed to attend, participate in, or observe activities sponsored or conducted by Horse Sense, or be present on the property on which Horse Sense conducts its activities, client does agree to hold harmless and release Horse Sense, its officers, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on Horse Sense's behalf and the owner(s) of any horse or other property used by Horse Sense, from all claims, demands, causes of action, and legal liability, whether the same be known or unknown, anticipated or unanticipated even if due to negligence and/or other clients' acts or omissions. Client does further agree to waive all rights which may otherwise arise from an injury to client or client's property, and shall not bring any claims, demands, legal actions or causes of action, against Horse Sense, those persons described above, or any person or entity, for any economic or non-economic losses due to bodily injury, death, or property damage arising out of the activities of Horse Sense or client's presence on or proximity to property used by Horse Sense.

3. **Indemnity.** Client agrees to be responsible for any and all damages, injuries, or loss of life caused by client or a horse in the care, custody and control of client, and to indemnify Horse Sense and all parties described above, for any losses or expenses (including attorney fees) which they incur in connection with claims related to client.

4. **Risks.** According to the North American Horseman's Association, numerous obvious and non-obvious inherent risks are always present in horseback riding and being around horses, despite all safety precautions. No horse is a completely safe horse. Horses are 5 to 15 times larger, 20 to 40 times more powerful and 3 to 4 times faster than a human. If a client falls from a horse to the ground it will generally be at a distance of 3 to 5 feet, and the impact may result in injury to the client. If a horse is frightened or provoked it may divert from its training and act according to its natural instincts which may include, but are not limited to: stopping short, changing direction or speed at will, shifting its weight from side to side, bucking, rearing, biting, kicking or running from danger. These risks exist for any person around a horse, whether mounted or on the ground. Client acknowledges these risks and states that she/he is not relying on Horse Sense to advise of all the risks.

5. **Acknowledgment and Assumption of Risks.** Client acknowledges that she/he bears responsibility for her/his own safety and client should not participate in any client activity unless she/he is confident that she/he can do so safely. Participation in equine activities with or conducted by Horse Sense constitutes a knowing and voluntary assumption of all risks associated with equine activities involving Horse Sense or being present on or using Horse Sense property (including but not limited to inherent risks and the risk of negligence by Horse Sense or others) which is a defense under North Carolina law to any claim for injury or damage, and a bar to recovery.

6. **Helmet Use.** Client acknowledges that wearing a properly fitted and secured client riding helmet which meets or exceeds the quality standards of the SEI Certified ASTM Standard F1163 while riding, mounting, dismounting and being near horses **may** reduce the severity of head injuries or prevent death occurring as the result of a fall or other occurrence. Horse Sense makes no representations as to the condition, effectiveness or suitability of any helmet it may allow client to use. All helmet related risks are assumed by client.

7. **Visitors.** Should client bring to Horse Sense any person who is not a party to an Equine Activity Liability Agreement with Horse Sense, client agrees to educate them as to the risks of being around horses and horse operations, supervise them, be solely responsible for their safety, and to be financially responsible for any injury or loss caused by or suffered by any such person.

8. **Safety Rules.** Client agrees to follow such rules for safety as are attached or are subsequently provided to them, or posted. Client acknowledges that failure to follow Horse Sense safety rules or the directions of Horse Sense's staff may put her/him at risk of, or increase the risk of, personal injury.

9. **Premises Inspection.** Client has inspected the farm's premises and facilities and/or have in some other way satisfied himself/herself that the condition of the premises and the facilities will provide an adequate and reasonable level of safety for client and any guests, or visitors they bring on the premises.

10. **Other Terms.** This document states the entire agreement between the parties as to liability and may not be changed, except in writing signed by the parties. The benefits of this agreement, including the release of legal liability, waiver of rights, indemnity and covenant not to sue, are intended to benefit others, including Horse Sense's officers, directors, shareholders, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on Horse Sense's behalf and the owner(s) of any horse or other property used by Horse Sense. This agreement shall be binding upon Horse Sense, client, and client's heirs or estate, when signed by the parties. If any clause, phrase or work is in conflict with State Law then that single part is null and void. This agreement and acknowledgments shall remain in force until terminated by client through written notice to Horse Sense at the address above. The General Court of Justice Madison County, North Carolina shall be the exclusive venue for any litigation between client and the parties described above.

Warning

Under North Carolina Law an equine activity sponsor or an equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina General Statutes.

Client Signature

Date

Signature of Client's Parent/Guardian

Date



Horse Sense of the Carolinas Inc. ***Policies & Consent for Treatment***

General Payment Policy: *Horse Sense of the Carolinas, Inc.* offers four options for payment: private pay (cash, check or credit card), private insurance through a superbill given to you, Medicaid/Medicare and limited scholarships. There is a \$35 service charge on all returned checks. In the event that an account goes to collections, there is a 20% collection fee added to the balance. For grant-funded clients, this payment policy applies to the missed appointment or late cancellation fees, should a client miss or late cancel appointments.

Charges for Phone Consultation: Appointments should be scheduled for extended conversations or questions. Brief consultations will be charged in 15 minute increments as usual rates. Please note: most insurance companies will not pay claims for phone consults.

Rates: The charge for an initial evaluation is \$140. The charge for individual, family, or couples therapy is \$120 for a 50 minute session and \$180 for a 70 minute session. Group therapy rates vary depending on group size and type. Group rates can be discussed with our program administrator. These charges apply to traditional and equine assisted family therapy. Payment for services is due at the time services are rendered.

Consent for Release of Information: In some cases *Horse Sense of the Carolinas, Inc* may find it necessary, or may be required by law or rules governing your health insurance to communicate, bill, or facilitate claims processing. By signing this agreement you are granting release of information rights to *Horse Sense of the Carolinas, Inc*, its d/b/a's and staff to provide data necessary to process claims or facilitate receipt of payment.

Appointment Cancellation Policy: "Failed Appointments" are defined as any occasion in which client does not come for the scheduled appointment. Please make every effort to keep your appointment. Your session is usually blocked out on our appointment book as a 50 minute hour. It is your time and seldom if ever can a session be filled on the spur of the moment. Therefore, failed appointments are billed to the client at the regular fee. The charges can not be submitted to your insurance company for reimbursement. Failed appointment charges should be paid upon receipt of notice of failed appointment.

"Late Cancellations" are defined as any cancellation made within twenty-four (24) hours of your appointment time. Please make every effort to avoid canceling your appointment within twenty-four (24) hours of your scheduled time. This time has been reserved for you and it is often very difficult or impossible to fill appointments on short notice. Therefore, late cancellations are billed to the client at the regular fee. The charges can not be submitted to your insurance company for reimbursement. Late cancellation charges should be paid upon receipt of notice of late cancellation. If a client is more than 15 minutes late for a session, the session may need to be rescheduled and late cancellation fees may be charged.

Release of Medical Information to Clinical Contracts or Horse Sense of the Carolinas, Inc Clinical Employees: By signing this agreement you are granting full consent for release of information to any other *Horse Sense of the Carolinas, Inc* clinical personnel who may be involved in your care, treatment planning, equine therapy activities, or related clinical services. Signing this agreement also serves as consent to release information needed to file claims made to insurance companies.

Privacy Policies: All sessions and their content, as well as the client's records will be kept strictly confidential. To the extent possible, clients will be informed before confidential information is disclosed, and in that event only the essential information will be revealed. Clients may request restrictions on the uses or disclosures of Protected Health Information, with the exceptions listed below. Diagnosis may be made; if so, diagnosis becomes a part of the client records. The only times a client's records may be shared without your consent are: 1) Client is in danger to self or others, 2) Therapist has knowledge of client being abused or neglected and/or 3) Disclosure is required by the court.

Emergency Policy: In the case of an emergency, go to the nearest Emergency Department or call 911.

3 Methods of Payment

Private Pay Clients

- Cash, Check, Visa, Mastercard, American Express or Discover payment for individual, family and couples sessions is due at the beginning of each session.

Private Insurance Clients

- We provide you with a copy of a superbill for your session, which you can then file with your insurance company for direct reimbursement to you. Payment for Private Insurance clients is due at the time services are rendered. If you are uncertain about how to do this, please request "Advocating for your Services" from us, a guide to understanding how this procedure works.

Medicaid Clients

- We require the following information **before** your first appointment (to be included on registration form)
 1. Copy of your current Medicaid card.
 2. Primary Care Physician *full* name.
 3. *Carolina Access #* of Primary Care Physician.
 4. Primary Care Physician's Practice Name.

Sliding Scale Fee & Scholarship information available upon request

(client must mail proof of income & be accepted into this program **before** first appointment)

HIPAA Notice of Receipt of Privacy Practices

- I acknowledge that I have been informed about the Notice of Privacy Practices for Horse Sense of the Carolinas, Inc
- I understand that the Notice of Privacy Practices discusses how my protected health information (PHI) may be used and/or disclosed, my rights with respect to protected health information, and how and where I may file a privacy related complaint.
- I may review a copy of this Notice in Horse Sense of the Carolinas, Inc waiting room and I have been offered a copy from the therapist.

Consent for Treatment. I, _____ (please print name), have read and thoroughly understand this document. I have read the Privacy Policy information and understand the therapist's responsibility to make such decisions when necessary. By signing, I give consent to receive ongoing outpatient treatment at *Horse Sense of the Carolinas, Inc.*

(If signing as a legal guardian for a dependent, please print

name of dependent _____, and

dependent's date of birth _____ for whom you give consent for treatment.

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

Signature

Date



Horse Sense of the Carolinas, Inc. Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to your health information.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our legal and ethical obligation to keep your information secure and confidential whether on paper, oral, or in an electronic form.

How we might use your medical information

We will use your medical information for providing treatment, such as by looking at your records to use your medical history for current treatment; and/or payment, such as when a payer requests copies of your medical information to pay a claim; and/or for healthcare operations, such as for internal auditing. We may contact you to help provide you with information concerning your health. We may also contact you to remind you of an upcoming appointment, taking care not to reveal any of your medical information. You have a right to ask us not to contact you using this method. I understand that as a part of my healthcare, Horse Sense originates and maintains health records describing my health history, symptoms, examination on test results, diagnosis, treatment, and any plans for future care or treatment for up to seven years after the date of my last session at Horse Sense. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Use and disclosure of your health information in certain special circumstances; the following circumstances may also require us to use or disclose your health information without your consent or authorization:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. You can request that Horse Sense of the Carolinas, Inc communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have a right to ask for a complete accounting of disclosures that were not authorized or otherwise permitted as listed above. You may revoke your authorization to disclose your medical information at any time.
4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. In order to receive a copy of your records, Horse Sense will charge you fifty cents (.50) per page. You must submit your request in writing and in person to Horse Sense of the Carolinas, Inc., Attn.: Office Manager. Before receiving your records, you must make an appointment with your therapist, so he or she can go over your records with you, in case you have any questions.
5. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for Horse Sense. To request an amendment, your request must be made in writing and submitted to Horse Sense of the Carolinas, Attn.: Office Manager. You must provide us with a reason that supports your request for amendment.
6. You have a right to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. Horse Sense reserves the right to change their notice and practices and if the terms do change, you may obtain a revised Notice by contacting Horse Sense of the Carolinas, Inc by mail or by asking your therapist.
7. You have a right to file a complaint. If you believe that your privacy rights have been violated, you may file a complaint with (1) Horse Sense of the Carolinas, Inc or with (2) the Secretary of the Department of Health and Human Services. Both addresses are provided at the bottom of this form. All complaints must be submitted in writing. To file a complaint with Horse Sense, contact the Office Manager. You will not be penalized for filing a complaint.
8. You have a right to provide an authorization for other uses and disclosures. Horse Sense of the Carolinas, Inc will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions about this notice or our health information privacy practices, please contact Horse Sense of the Carolinas, Inc.

Horse Sense of the Carolinas, Inc
6919 Meadows Town Road
Marshall, NC 28753
Telephone: (828) 683-7304
FAX: 1-877-696-6775

US Dept. of Health and Human Services
200 Independence Avenue, S.W.
Washington DC, 20201
Telephone: (202) 619-0257
Web site: www.hhs.gov/

Horse Sense of the Carolinas, Inc Client Rights and Responsibilities

Client Rights

- | | |
|---|--|
| <ul style="list-style-type: none">◆ To receive considerate and respectful services.◆ To receive services which demonstrate sensitivity to and respect for diverse cultural backgrounds.◆ To receive services without regard to ethnicity, sex, age, handicapping condition, national origin, sexual orientation or economic status.◆ To receive current and complete information concerning his/her diagnosis, treatment, and prognosis in terms he/she can understand from the members of the professional staff assigned to his/her case.◆ To know by name, specialty, and qualifications the members of staff assigned to his/her case.◆ To have the consideration of privacy and individuality as it relates to social, religious and psychological wellbeing.◆ To have the respectfulness and privacy as it relates to his/her individual care program. Case discussion, consultation, examination, and treatment are confidential and are conducted discreetly.◆ To obtain information on the relationship of Horse Sense of the Carolinas to other health care and related agencies insofar as his/her care is concerned.◆ To be fully informed, prior to or at the time of his/her initial appointment, of services available and of related charges.◆ To participate in the planning of his/her treatment to be fully informed of any risks or hazards associated with his/her treatment, to refuse treatment, and to refuse to participate in experimental research. | <ul style="list-style-type: none">◆ To not be arbitrarily discharged, or transferred to another service provider. Clients may be transferred or discharged only for clinical reasons, for his/her welfare, for other clients' welfare, or for nonpayment of services. Reasonable advance notice or any transferor discharge must be given to a family/client.◆ To be encouraged and assisted to understand and exercise his/her rights and, to this end, have the right to voice grievances and recommend changes in policies and services to Horse Sense of the Carolinas staff and outside representatives of his/her choice, free from restraint, interference, coercion, discrimination, or reprisal.◆ To be free from mental and physical abuse, neglect, and exploitation and be free from chemical and physical restraints, except in emergencies, or as authorized in writing by his/her physician or other appropriately licensed professionals for a specified and limited period of time, and when necessary to protect the client from injury to him/herself or to others.◆ No client/family shall be required to provide services for Horse Sense of the Carolinas, Inc.◆ To have the assurance of confidential treatment of his/her clinical records and may approve or refuse their release to any individual outside Horse Sense of the Carolinas, except as otherwise provided by law, or a third party payment contract.◆ To expect a reasonable response to his/her requests.◆ To expect reasonable continuity of care. |
|---|--|

Client Responsibilities

- | |
|---|
| <ul style="list-style-type: none">◆ To keep appointment or notify Horse Sense of the Carolinas, Inc. of necessary cancellations 24 hours in advance.◆ To pay for services to the extent that he/she is able. Services may be refused if a client/family is able but unwilling to pay. Horse Sense of the Carolinas, Inc. has a sliding fee scale based on family income.◆ To inform Horse Sense of the Carolinas, Inc. of relevant changes in location or status – address, telephone number, insurance coverage, etc.◆ To follow through on service plan recommendations and procedures to which he/she had agreed or to specifically communicate his/her withdrawal of consent to any Horse Sense of the Carolinas, Inc. staff member. |
|---|

**To report any problems or changes, please contact your therapist. If you believe you have been denied any of the above rights, you may contact Horse Sense of the Carolinas, Inc. by mail at:
6919 Meadows Town Rd., Marshall, NC 28753**



CONSENT FOR DATA TO BE USED IN RESEARCH STUDIES

Horse Sense of the Carolinas, Inc. asks that clients complete questionnaires prior to beginning therapy and after completing therapy. The purpose of these questionnaires is to help the staff at *Horse Sense of the Carolinas, Inc.* learn about the effectiveness of Equine Assisted Psychotherapy (EAP). The questionnaires that are used are the Outcome Questionnaire (OQ), and the Youth Outcome Questionnaire (YOQ), which allows the client to describe and rate the types of troublesome behaviors or problems they are experiencing.

The pre and post results of these questionnaires are later combined with results from other clients and are used to measure the program's effectiveness. Client's names are not used or associated with the results in any way. Basic information such as age and gender may be used when summarizing results, though client names remain entirely confidential.

Results from these questionnaires might also be summarized for publication in order to contribute to the literature and research available to help learn more about the effectiveness of EAP.

By signing this consent form, you are giving *Horse Sense of the Carolinas, Inc.*, permission to use the results of the Outcome Questionnaire or the Youth Outcome Questionnaire for research studies.

I understand the above and give my consent for results of this questionnaire to be used for research purposes. I understand that the names of clients will not be used in any way.

Client's Name

Client's Date of Birth

Legal Guardian

Date



Horse Sense of the Carolinas, Inc. EAP Check-Out Form

Name: _____ Date: _____ Therapist: _____

Session CPT Code (Check appropriate box)

- _____ 90801 Psychiatric Diagnostic Interview Evaluation
- _____ 90804 30-Minute Individual Psychotherapy
- _____ 90806 50-Minute Individual Psychotherapy
- _____ 90808 80-Minutes Individual Psychotherapy
- _____ 90853 Group Psychotherapy
- _____ 90847 Family Therapy, Client Present
- _____ 90846 Family Therapy, Client Not Present
- _____ 90849 Group Therapy (multi-family)
- _____ OTHER (specify) _____

Session Type (if applicable):

- _____ Gang Violence Prevention Program
- _____ JCPC County (B, M, Y, H)
- _____ JCPC Group (ITH, HP RITB)
- _____ Teen Sense
- _____ Body Sense
- _____ Dudes
- _____ Sister Sense
- _____ Girls Rule
- _____ Court Referred Assessment
- _____ OTHER (specify) _____

Diagnosis: _____

NEXT Appointment:

_____ 1 Week _____ 2 Weeks _____ 3 Weeks _____ 4 Weeks _____ 6 Weeks _____ Other: _____

Therapist Signature: _____

Horse Sense of the Carolinas, Inc. 6919 Meadows Town Road Marshall NC 28753 (o) 828-683-7304 (f) 828-683-6281

www.horsesenseotc.com

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Treatment Plan

Client's Name: _____ Date of Birth: _____ Today's Date: _____

Goals	Services/Interventions (including frequency)	Responsible Person/Position

Target Date	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal:

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued



Session Progress Note

Name _____ Client Number _____ Date _____

Day M T W Th F Sat Start Time _____ (am/pm) End Time _____ (am/pm) Duration _____

_____ 90806 Individual Therapy 50 minutes

_____ 90808 Individual Therapy 75 minutes

_____ 90847 Family Therapy with Client

_____ 90846 Family Therapy without Client

_____ 90849 Multi-Family Therapy Group

_____ 90853 Group Therapy (non-interactive)

_____ Other _____
(code)

Purpose of Contact: problem/goal/topic: _____

Intervention: _____

Effectiveness: (If group, client initials only for other group members).



Discharge Summary

Client's Name: _____ Date of Birth: _____ Age: _____

Parent/Guardian Name: _____

Complete A or B:

A Discharge and Closed Case at Horse Sense of the Carolinas, Inc.

Date of First Session: _____ Date of Last Session: _____

Number of Sessions: _____ Type of Termination: _____

Referral at Termination: _____

OR

B Discharge and Transfer to Another Program

Organization: _____ Responsible Person: _____

Treatment Goals:

1. _____
2. _____
3. _____

Interventions (check all that apply):

Individual Therapy Couples Therapy Family Therapy Group Therapy

Emergency Service Other: _____

Were Goals Met? (check one for each):

yes no N/A 1. _____

yes no N/A 2. _____

yes no N/A 3. _____

Compliance with Treatment (check one):

good needs reinforcement poor Comments: _____

Description of Closing Session:

Disposition/ Prognosis:

_____ (next page)

Client's Name: _____ Date of Birth: _____ Age: _____

Assessment of Dangerousness to Self or Others:

Is there a history of dangerousness to self or others? ___yes ___no

If yes, indicate present status: _____

Ever involuntarily committed? ___yes ___no

Consults/ Referrals:

Follow Up Contact:

Signature of *Horse Sense of the Carolinas, Inc.* Therapist

Date

Signature of *Horse Sense of the Carolinas, Inc.* Equine Specialist

Date



Horse Sense of the Carolinas, Inc. General Feedback Form

Session Type: _____ Dates: _____

Thank you for your participation in our program. In order to improve our services, we'd like to get your feedback on your experience with Horse Sense of the Carolinas, Inc. Please take a moment to answer the following questions.

1. Was this a valuable experience for you? Why or why not?
2. How have your goals been accomplished, changed, or unmet since you first started?
3. What would you like to see improved, added, or changed?
4. What did you learn about yourself during your time here?
5. How did the horses help you gain perspective about your life?
6. May we quote you (using your first name and last initial), in our promotional material?
(circle) Yes No
If yes, please provide your first name and last initial here: _____
7. May we use a picture of you (using your first name and last initial) in our promotional material?
(circle) Yes No
If yes, please provide your first name and last initial here: _____



Parent Feedback Form

Session Type: _____ Dates: _____

Thank you for your participation in our program. It has been a pleasure to work with you and your child. In order to improve our services, we'd like to get your feedback on your experience with Horse Sense of the Carolinas, Inc. Please take a moment to answer the following questions.

1. Was this a valuable experience for you and your family? Why or why not?

2. How have your child's goals been accomplished, changed, or unmet since first starting?

3. What would you like to see improved, added, or changed?

4. What have you learned about your child since he/she started at Horse Sense? Has his/her behavior changed at home? If so, how?

5. How did the horses help your child gain perspective about his/her life?

6. May we quote you, using your initials only, in our promotional material
(circle) Yes No
If yes, please provide your initials here: _____

7. May we use a picture of you or your child, using initials only, in our promotional material?
(circle) Yes No
If yes, please complete the form on the back. (over)



Team Feedback Form

Session Type: _____ Dates: _____

Thank you for your participation in our program. In order to improve our services, we'd like to get your feedback on your experience with Horse Sense of the Carolinas, Inc. Please take a moment to answer the following questions.

1. Was this a valuable experience for you? Why or why not?
2. How have your goals been accomplished, changed, or unmet since you first started?
3. What would you like to see improved, added, or changed?
4. What did you learn about yourself during your time here?
5. How did the horses help you gain perspective about your team?
6. May we quote you, using your initials only, in our promotional material

(circle) Yes No

If yes, please provide your first initials here: _____

7. May we use a picture of you, using initials only, in our promotional material?

(circle) Yes No

If yes, please complete the form on the back. (over)



horse sense business sense



PRACTICAL TOOLS FOR BUILDING A SUCCESSFUL EQUINE ASSISTED PROGRAM

Thanks for your dedication to the field, and if you have any questions, please don't hesitate to contact us at info@HorseSenseOtc.com.

To learn more about this and about other Horse Sense solutions for EAP/EAL businesses, visit www.HorseSenseOtc.com. Check out all the opportunities to gain valuable information through free:

- Free Telecalls
- Teleclasses
- Consulting Packages
- Onsite and Off Site Workshops, and much more.