ANIMALS AS NATURAL THERAPY

P.O. Box 31595 • Bellingham, WA • 98228
Phone/Fax: 360-671-3509 • www.animalsasnaturaltherapy.org

Veteran Equine Program Registration

Participant Name: _____ Date of Birth: _____

Pronouns: _____ Weight: _____ Height: _____ (for riding purposes)

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Email Address: _____

Address/Phone (if different from above): _____

In case of emergency: Contact: _____ Phone: _____

Contact: _____ Phone: _____

Liability Release:

I, _____(Participant's name) would like to participate in Animals as Natural Therapy programs. I acknowledge the risks and potential for risks of horse and farm activities. However, I feel that the possible benefits to myself 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 Animals as Natural Therapy, Inc., its Board of Directors, Instructors, Therapists, Volunteers and/or Employees for any and all injuries and/or losses I may sustain while participating in Animals as Natural Therapy programming. I understand that these programs may include therapeutic counseling.

Date: _____ Signature:_____

Photo Release (OPTIONAL):

I hereby consent to and authorize the use and reproduction by Animals as Natural Therapy of any and all photographs and any other audiovisual materials taken of me for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date: _____ Signature:_____

Consent for Treatment and Release of Liability for EAMHT

Although every effort will be made to avoid accident and injury, NO LIABILITY can be accepted by any of the organizations concerned including Animals as Natural Therapy and/or Joaquin Aguirre, MA, Certified Counselor, its officers, trustees, agents, employees, each and every one of its members and associates, and the property owners upon whose land the EAMHT sessions are conducted.

"I request and consent to treatment that may include EAMHT. I understand that no liability can be accepted by any of the organizations concerned with this therapy, including Animals as Natural Therapy and/or Joaquin Aguirre, MA, Certified Counselor."

Date: _____ Signature: _____

Participant's Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Animals as Natural Therapy to secure and retain medical treatment and transportation if needed.

Full Name: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Co: _____ Policy #: _____

Consent Plan

This authorization includes x-ray, surgery, hospitalization, and medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature: _____

Print name: _____

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event of emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

Date: _____ Consent Signature: _____

Print Name: _____

Participant's Medical History

Complete information is needed to ensure instructor awareness and sensitivity to your behavior and needs and will not be used to screen out participants.

(Explain "yes" answers below)	**Yes**	**No**
1. Any recent injury, illness, or infectious disease?	◯	◯
2. Chronic recurring illness/condition?	◯	◯
3. Frequent headaches?	◯	◯
4. Ever had head injury?	◯	◯
5. Wear glasses, contacts, or protective eyewear?	◯	◯
6. Ever passed out during or after exercise?	◯	◯
7. Ever had seizures?	◯	◯
8. Chest pain during or after exercise?	◯	◯
9. High blood pressure?	◯	◯
10. Back problems?	◯	◯
11. Joint problems (e.g., knees, ankles)?	◯	◯
12. Orthodontic appliance or headgear being used?	◯	◯
13. Any skin problems (e.g., allergies, rash, hives)?	◯	◯
14. Diabetic?	◯	◯
15. Asthmatic?	◯	◯
16. ADD/ADHD diagnosed?	◯	◯
17. Short or long-term memory impairment?	◯	◯
18. Tendencies toward emotional/violent outburst or inflicting harm to self, others or animals?	◯	◯

Please explain any "yes" answers, noting the number of the question.

_____

_____

_____

Date of last Tetanus (if known): _____ **Known allergies:** _____

_____

Reaction to bee stings? _____ **Medications that will be taken during visits or to be aware of in case of an emergency:** _____

Is there any health reason to limit your activities or that would be helpful for us to know? _____

_____

What would you most like to experience with Animals as Natural Therapy? _____

_____

_____

_____

ANIMALS AS NATURAL THERAPY

Exceptions to Confidentiality

The privacy of your personal information is of utmost importance. ANT is compliant with current Federal and State of Washington laws. Federal and State laws limit confidentiality. ANT may use or disclose your personal health information when we are required or permitted to do so by law, or in the following situations:

a) Duty to warn: Participant's personal health information may be disclosed if we determine a need to alert an intended victim of a serious threat to their health or safety. For example, this may occur if participants reveal intentions to kill or harm another person. ANT is obligated to take necessary action to avert a serious threat to the health and safety of others.

b) Danger to participant: Participant's personal health information may be disclosed if ANT determines that participants may kill or seriously harm themself. For example, this may occur if participants reveal that they are planning to attempt suicide. ANT is obligated to take necessary action to avert a serious threat to their health or safety.

c) Child or elder abuse or neglect: Participant's personal health information may be disclosed if they report or ANT reasonably suspects any child or elder abuse or neglect. For example, if participants reveal that they have physically harmed a child then ANT will need to notify Child Protective Services (CPS).

d) Court order: Participant's personal health information may be disclosed if ANT is presented with a court order to do so. For example, this may occur if participants have legal involvement and a judge or law enforcement agency has called ANT to testify or release records.

e) Crime against ANT or office premises: participant's personal health information may be disclosed if they commit or threaten to commit a crime against ANT or within office premises. This includes damage to property.

f) Other disclosures: participant's personal health information may be disclosed for research when approved by an institutional review board, to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Participant's personal health information may be disclosed to necessary parties involved if you file a legal or administrative claim against ANT's business. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for ANT's professional services by our agreed upon time period.

Date: _____ Signature: _____

Consent for Treatment and Release of Liability for EMHT

Animals as Natural Therapy
P.O. Box 31595
Bellingham, WA 98228
360-671-3509

"Although every effort will be made to avoid accident and injury, no liability can be accepted by any of the organizations concerned including Animals as Natural Therapy and/ or Jack (Joaquin) Aguirre M.A., LMFT, its officers, trustees, agents, employees, each and every one of its members and associates, the property owners upon whose land the EAMHT sessions are conducted."

I request and consent to treatment that may include EAMHT. I understand that no liability can be accepted by any of the organizations concerned with this therapy, including Animals as Natural Therapy and or/Jack (Joaquin) Aguirre M.A., LMFT.

Participant's Name: _____

Signature: _____

Date: _____

Jack S. Aguirre M.A., LMFT
Washington State License Counselor # LF 00002681
360-318-6375
Disclosure Form

Type and Length of Counseling Provided:

Welcome to Animals as Natural Therapy! I look forward to working with you and would like to familiarize you with my background, and counseling approach so that you may be an informed client. We offer counseling to individuals, couples, families and groups. Sessions for counseling individuals are up to 60 minutes and groups approximately 1 ½ hours. The number of sessions will be based on your eligibility and also been determined between the two of us.

These sessions are designed to assist you in challenges you are facing in life. While participating in counseling, you may experience various feelings which may cause some distress. However, if you are concerned that we are not working toward your goals, you are encouraged to address these concerns so we can address them together.

Procedure: I work with clients by appointment. Please arrive on time for sessions. As a courtesy to me and others who may wish to schedule, please give as much notice as possible if you need to cancel or change appointment(s). Clients will be expected to pay a no-show late cancellation fee unless 24-hour notice is given, please see on next page for policy.

Emergencies: if you find yourself in crisis, please contact me via the numbers I have provided, or contact one of the following crisis numbers: Care Crisis Response: 1-800-584-3578/Call 911/Get to the nearest hospital Emergency Room.

Theoretical Orientation: My theoretical orientation is eclectic in nature and utilizes, when needed, Family Systems approaches, Cognitive Behavioral and Psychotherapeutic approaches. My techniques include reflection on behavior, ways to correct maladaptive behavior as well as thoughts, and integration of new learning, including acquisition of and self-mastery of coping skills.

Education and Training: My Bachelor's degree was completed in Santa Barbara, California, at Westmont College, while my master's in counseling psychology with an emphasis in Marriage, Family and Child Counseling was earned at Chapman University in Orange, California. I acquired a Washington state license as a Marriage and Family Therapist in 2008. My training, education, and experience includes the schools mentioned and in community mental health since 1987, as well as in a variety of settings including inpatient psychiatric hospitals, private practice, and outpatient services. The challenges my patients or clients have faced include traumas from abuse, physical injury, war, and family chaos. My continuing education includes focus on the treatment of PTSD, Family Systems, and cognitive distortions. I have completed training as a Trauma Response Specialist, Biofeedback and Neurofeedback with a certificate of completion in each.

Ethics and Professional Conduct: We will uphold strict ethical standards in our work with you. However, if you feel your therapist has acted in an unethical or unprofessional manner, you may contact the department of health counselor programs division in Olympia. Contact information is as follows: Health Professions Quality Assurance; Customer Service Center; PO Box 47865; Olympia, WA 98504; Email: hpqa.csc@doh.wa.gov; phone: (360)236-4700 Fax: 360-236-4818

Please feel free to ask questions or discuss any part of this disclosure form with me. Please sign this form, indicating that you have read and understand its contents.

Signed_____ (Client) Date_____

Signed_____(Therapist) Date_____

Rain or Shine Policy

Animals as Natural Therapy programs operate rain or shine. In the case of inclement weather or natural disaster ANT staff will contact you at least 2 hours prior to your committed time to cancel.

I have read this policy and understand that I am committed to showing up for program unless ANT has cancelled.

Name of responsible party: _____

Signature of Responsible Party: _____ Date: _____

Participant Financial Agreement

Charges for ANT's Private sessions (with a therapist present) are $175 for 60-minutes, session charges for a session without a therapist present are $140 for 60-minutes. Payment is due weekly. Statements will be sent out monthly. This statement will also show any financial assistance granted. Please disregard session payments if you are registered as a Warrior with Wounded Warrior Project.

Limited partial scholarships are available based on a sliding fee scale. To apply, please contact our program coordinator. Financial Assistance Forms must be submitted before sessions commence. Proof of income is required.

Absence Policy:

- Please notify us at least 24 hours in advance if you will be absent. You are considered "unexcused" if notice is given less than 24 hours prior to your session time. Exceptions will be made regarding emergency or sudden illness. If it is emergency or sudden illness please let us know at least 2 hours prior to your scheduled session time or we will mark you as unexcused.
- **We understand that emergencies do arise; however, an instructor fee will be charged for last minute cancellations & unexcused absences, equal to:**
  - Half the normal session fee for full-pay participants
  - Full agreed-upon session fee for scholarship participants
- If a participant misses two (2) sessions without notice, future sessions will be cancelled for the quarter and no further financial assistance will be given.

I have read this policy and understand that I am responsible for any necessary payment and attendance.

Name of responsible party: _____

Signature of Responsible Party: _____ Date: _____