Unbridled Hope

An Equine Assisted Growth and Learning Program of
Wellspring Counseling Ministries

A Project of United Charitable, a 501(c)(3) registered public charity. Tax ID 20-4286082
603 West F Street ~ Oakdale, CA 95361
209-607-1887 ~ fax 209-848-8825

Registration & Limits of Confidentiality

CLIENT INFORMATION:

Name_____ Date of Birth_____ Male / Female

Street Address_____ City _____ State _____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Mailing Address (If different from above) _____

Message Phone ( ) _____

Emergency Contact: _____ Phone ( ) _____

Are you currently taking any prescribed medication? If so, please list here. _____

_____

As a child, who did you feel closest to? ☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Other _____

Rate your childhood: ☐ Very happy ☐ Happy ☐ Average ☐ Unhappy ☐ Very unhappy

LIMITS OF CONFIDENTIALITY

Each individual's rights to confidentiality need to be clearly explained. By professional ethics and by law, you have the right to confidentiality, and the mental health specialist is prohibited from revealing to any other person what you have said to him/her without your written permission. There are three (3) instances in which your right to privacy must be set aside *without* your permission:

1. If you initiate a lawsuit against someone, his/her right to the best defense supersedes you right to confidentiality. His/her attorney has the right to subpoena your records, take the mental health specialist's deposition, have him/her appear in court, or all three.

2. If you, your spouse, or some of your dependents specifically or vaguely disclose information indicating sexual, physical, or severe emotional child abuse, elder abuse, or the abuse of a developmentally disabled person, the mental health specialist must call the protective services immediately and submit a follow-up written report ASAP; and

3. If your mental health specialist believes, from the information that you disclose, that you are in danger to yourself or to someone else, he/she must notify the local authorities and person(s) in danger.

Failure to comply with the law relating to items 1-3 above can render the mental health specialist liable to punitive action such as loss of license, imprisonment, fine(s) or civil lawsuit for malpractice.

If applicable: Clients should be aware that the use of insurance requires his/her agreement (by right of the insurance carrier) to free access to the mental health specialist's records. This represents a compromise of a client's right to confidentiality since insurance companies may place this information in a larger industry-wide computer data base. Any concerns in this regard should be addressed to your insurance carrier. *For more specific information, please refer to the Notice of Privacy Practices.*
I hereby give permission for mental health treatment for the client above. I hereby acknowledge receipt of Limits of Confidentiality**.** I acknowledge that I have read and received a notice of Privacy Practices.

Client Signature:_____Date:_____

Participant Agreement, Release, and Acknowledgement of Risk for the Equine Assisted Growth and Learning Services of Cindi J. Martin, LCSW (hereafter referred to as CJM) in Cooperation with Wellspring Counseling Ministries (WCM), which is a Project of United Charitable, a 501(c)(3) public charity. Tax ID 20-4286082

In consideration of the services of CJM & WCM and their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf, I hereby agree to release, indemnify, and discharge CJM & WCM on behalf of myself, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I acknowledge that horseback riding, caring for horses, spectating, and all therapeutic activities that involve horses entail unknown and unanticipated risks which could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. ***I further understand that if I have brought my horses or animals or any third party to this property, that additional unknown and unanticipated danger and risk exist for them and that the risks may result in serious injury, paralysis or death.*** I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity. I agree to wear long pants and boots when participating in any activity involving horses and I further agree to wear a helmet when horseback riding.

The risks include, among other things: loss of control, collisions; horses, irrespective of their previous behavior and characteristics may act or react unpredictably based upon instinct, fright, or lack of proper control by rider, latent of apparent defects or conditions in equipment, animals or property; acts of the other participants in this activity, adverse either conditions; contact with plants, insects or animals; my own physical condition or my own acts or omissions; the condition of remote roads, trails, waterways, ort terrain, and accidents connected with their use; first-aid, emergency treatment or other services rendered; consumption of food and drink. Furthermore, UBH & WCM and their agents have difficult jobs to perform. They seek safety, but they are not infallible. They might be unaware of a participant's (horse or human) fitness or abilities. They might misjudge the water, the elements or the terrain. They may give inadequate warnings or instruction, and equipment being used might malfunctions.

2. I expressly agree and promise to accept and assume all the risks existing with this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.
3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless CJM & WCM from any and all claims, demands, or causes of action, which are in any way connected with my or my animal's participation in this activity or my use of UBH & WCM's equipment or facilities, including any such claims which allege negligent acts or omissions of CJM & WCM and their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf.
4. Should CJM & WCM or anyone acting on their behalf be required to incur attorney's fees and cost to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating or else I agree to bear the costs of such injury or damage myself. I further certify that I have no medical or physical conditions which could interfere with my safety in this activity or else I am willing to assume and bear the costs of all risks that may be created, directly or indirectly by such condition.

5. In the event that I file a lawsuit against CJM & WCM, I agree to do so solely in the state of California and I further agree that the substantive law of that shall apply in that action without regard to the conflict of law rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity or any other activity involving other animals or persons, I may be found by a court of law to have waived my right to maintain a lawsuit against CJM & WCM and their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf on the basis of any claim which I have released them herein.

I have had sufficient opportunity to read this entire document. I have read and understood it and I agree to be bound by its terms.

Participant's Signature: _____Print Name_____

Address:_____

Phone_____ Date:_____

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Informed Consent for Research

Study Name: Wellspring Counseling Center Principal Investigator: Wellspring Counseling Center

PLEASE READ THIS DOCUMENT CAREFULLY. YOUR SIGNATURE IS REQUIRED FOR PARTICIPATION. YOU MUST BE AT LEAST 18 YEARS OF AGE TO GIVE YOUR CONSENT TO PARTICIPATE IN RESEARCH. IF YOU DESIRE A COPY OF THIS CONSENT FORM, YOU MAY REQUEST ONE AND WE WILL PROVIDE IT.

The policy is that all research participation is voluntary and you have the right to withdraw at any time, without prejudice, should you object to the nature of the research. You are entitled to ask questions and to receive an explanation after your participation.

Description of the Study: This is a twelve session study in which a number of different kinds of psychological tests and measures are being evaluated. To do this, we will ask you to do the following: Take a test before and after you participation in the Second Chances California program.

Purpose of the Study: The purpose of this study is to find out some general information about how our program impacts depression, anxiety, anger and stress management in our client's lives.

Possible Risks:

a) When filling out questionnaires, you may come across a question or answer choice that you find unpleasant, upsetting, or otherwise objectionable. For instance, a few of the questions may cause you to think about negative emotional states.

b) You may feel that you have performed poorly on a test. For many of the activities, tests and questionnaires we are evaluating, there is no right or wrong answer. For some activities, however, it is to be expected that some people will do better than others on some of the tests. We encourage you to discuss this with the test administrator during the debriefing period, when all procedures have finished.

c) You will be asked to provide confidential information about yourself.

Possible Benefits:

a) When your participation is complete, you will be given an opportunity to learn about this research, which may be useful to you in understanding yourself and others.

b) You will have an opportunity to contribute to psychological science by participating in this research.

Confidentiality: You will be assigned a code number which will protect your identity. All data will be kept in secured files. All identifying information will be removed from questionnaires as soon as your participation is complete. No one will be able to know which are your questionnaire responses. Finally, remember that it is no individual person's responses that interest us; we are studying the usefulness of the tests in question for people in general.

Opportunities to Question: Any technical questions about this research, questions regarding your rights as a research participant or to report any research-related injuries may be directed to: Principal Investigator: Unbridled Hope, (209) 602-7982

Opportunities to Withdraw at Will: If you decide now or at any point to withdraw this consent or stop participating, you are free to do so at no penalty to yourself. You are free to skip specific questions and continue participating at no penalty.

Opportunities to be Informed of Results: If you wish to be told of the preliminary and/or final results of this research, please contact: Principal Investigator: Unbridled Hope, (209) 602-7982. The Principal Investigator will either meet with you or direct you to where you can read a copy of the results. In addition, there is a chance that the results from this study will be published in a scientific psychology journal, which would be available in many libraries. In such an article, participants would be identified in general terms.

Your signature below indicates that you voluntarily agree to participate in this study.

Dated this _____ day of _____ (month), 20_____.

_____ _____

Signature of Participant Signature of Person Obtaining Consent

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Effective Date: Immediately

My Legal Duty:
I understand that your health/mental health information is personal, and I am committed to protecting this information. I am required by applicable federal and state law to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (H.I.P.A.A.), also requires that I give you this Notice about my legal duties, my privacy practices, and your rights concerning this Notice while it is in effect.

Individually, identifiable information about your past, present, or future health/mental health or condition, the provision of health/mental health care to you, or payment for the health/mental health care is considered "Protected Health Information (PHI)." Whenever possible, the PHI contained in your record remains private. In some circumstances, it is necessary for me to share some of the PHI contained in your record (or your child's record). In all but certain specified circumstances, I will share only the *minimum necessary* PHI to accomplish the intended purpose of the use or disclosure.

How I May Use and Disclose Health/Mental Health Information About You:
The following categories describe different ways that I use and disclose your PHI. For each category, I explain what I mean, and offer an example. In some instances a written authorization signed by you is required in order for me to use or disclose your PHI; in others, it is not. I have tried to identify which instances do not require your signed authorization and which do.

Uses and Disclosures of PHI for Which No Signed Authorization is Required:

For Treatment: I may use/disclose your PHI (or your child's) to provide you with mental health treatment or services. For example, I can disclose your PHI to physicians, psychiatrists, and other licensed health care providers who provide you with health care services or are involved in your care. If a psychiatrist is treating you, I can disclose your PHI to your psychiatrist in order to coordinate your care.

For Payment: I may use/disclose your (or your child's) PHI in order to bill and collect payment (from you, your insurance company, or another third party) for services provided by me. For example, I may send your PHI to your insurance company to get paid for the services provided to you or to determine eligibility for coverage.

For Health Care Operations: I may use/disclose your (or your child's) PHI to your health care service plan or insurance company for purposes of administering the plan, such as case management and care coordination.

Appointment Reminders or Changes in Appointments: I may use/disclose your (or your child's) PHI to contact you as a reminder that you have an appointment. I may also contact you to notify you of a chance in your appointment. For example, if I am ill, I may have someone in my office contact you to notify you that the appointment is cancelled. *If you do not wish me to contact you for appointment reminders or changes in appointment times, please provide me with alternative instructions (in writing).*

When Disclosure is Required by State, Federal or Local Law; Judicial or Administrative Proceedings; Or Law Enforcement: I may use/disclose your (or your child's) PHI when a law requires that I report information about suspected child, elder, or dependent adult abuse or neglect; or in response to a court order. I must also disclose information to authorities that monitor compliance with these privacy requirements.

To Avoid Harm: I may use/disclose limited PHI about you when necessary to prevent or lessen a serious threat to your health or safety, or the health and safety of the public or another person. If I reasonably believe you pose a serious threat of harm to yourself, I may contact family members or others who can help protect you. If you communicate a serious threat of bodily harm to another, I will be required to notify law enforcement and the potential victim.

Law Enforcement Officials: I may disclose your (or your child's) PHI to the police or other law enforcement officials as required or permitted by law, or in compliance with a court order, or grand jury, or administrative subpoena.

For Health Oversight Activities: I may disclose PHI to a health oversight agency for activities authorized by law. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

Specialized Government Functions: I may disclose you (or your child's) PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

Disclosure to Relatives, Close Friends and Other Caregivers: I may use/disclose your PHI to a family member, other relative, a close personal friend, or any other person that you indicate is involved in your care or the payment of your care unless you object in while or in part. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance. I may exercise my professional judgment to determine whether a disclosure is in your best interest. If disclosing PHI to a family member, other relative or a close personal friend, I would disclose only information that I believe is directly relevant to the person's involvement with your health care or payment related to your health care.

Workers' Compensation: I may disclose your PHI as authorized by and to the extent necessary to comply with California Law relating to workers' compensation or other similar programs.

As Required By Law: I may use and disclose you (or your child's) PHI when required to do so by any other law not already referred to in the preceding categories.

***Uses and Disclosures of PHI for Which a Signed Authorization is Required**:* For uses and disclosures of PHI beyond the areas noted above, I must obtain your written authorization. Authorizations can be revoked at any time in writing to stop future uses/disclosures (except to the extent that I have already acted upon your authorization).

Your Rights Regarding You, or Your Child's, Protected Health Information (PHI):

You have the following rights regarding your PHI, or that of your child's, that I maintain:

Right to Inspect and Copy: You have the right to inspect and copy your (or your child's) health/mental health information upon your written request. However, some mental health information may not be accessed for treatment reasons and for other reasons pertaining to California or Federal Law. I will respond to your written request to inspect records.

Right to Request Restrictions: You have the right to ask that I limit how I use or disclose your PHI. I will consider your request, but I am not legally required to agree to the request. If I do agree to your written request to inspect records. A charge for copying, mailing and related expenses will apply.

Right to Amend: If you believe that there is a mistake or missing information in my record of your health/mental health information, you may request in writing, that I correct or add to the record. I will respond to your request within 60 days of receiving it. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request to amend information that was not created by me, not part of my records, not part of the information that you would be permitted to inspect and copy or is accurate and complete.

Right to an Accounting of Disclosures: You have a right to get a list of when, to whom, for what purpose, and what content of your (or your child's) PHI has been disclosed. This applies to disclosures other then those made for purposes of treatment payment, or health care operations. Your request must be in writing and state a time period (which may not be longer than six years and may not include dates before December 1, 2012). I will respond to your request within sixty (60) days of receiving it. The first list you request within a 12 month period will be free. There may be a charge for more frequent lists. In such a case, I will notify you of the cost involved and you may choose to change or withdraw your request before any costs are incurred.

Right to Request Confidential Communications: You have a right to request that I communicate with you about health/mental health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must make your request in writing. Please specify how or where you wish to be contacted. I will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have a right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

Complaints:
If you think that your privacy rights have been violated you may contact me at (209) 602-7982, or your may file a complaint with the Secretary of the United States Department of Health and Human Services, at 200 Independence Avenue S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.