Stable TRANSFORMATION
PSYCHOTHERAPY FOR PEOPLE USING HORSES

Registration

Client Name _____
Legal Guardian Name_____
Address _____
City_____ State_____ Zip_____
Home Phone_____ Work Phone _____Ext_____
Cell Phone #_____
Date of Birth_____ Social Security Number_____
Relationship Status_____ Gender [ ] Male [ ] Female [ ] Other
Employer or School_____
Referred by _____

I, _____ agree to pay *Stable Transformation, LLC* 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.

Credit Card #: _____ - _____ - _____ - _____ Security Code: _____
This is required and will only be charged for unpaid balances.
CC Expiration Date: ____ / ____

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

_____ _____
Witness Signature **Date**

Stable Transformation, LLC.
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	☐	☐	_____
Visual	☐	☐	_____
Speech	☐	☐	_____
Cardiac	☐	☐	_____
Circulatory	☐	☐	_____
Pulmonary	☐	☐	_____
Neurological	☐	☐	_____
Muscular	☐	☐	_____
Orthopedic	☐	☐	_____
Allergies / Asthma	☐	☐	_____
Learning Disability	☐	☐	_____
Psychological Impairment	☐	☐	_____
Diabetes	☐	☐	_____
Drug allergy/reactions	☐	☐	_____
Other_____	☐	☐	_____

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:_____

Stable Transformation, LLC.
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 *Stable Transformation* 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)

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Emergency Medical Non-Consent

If the undersigned does not desire to grant any *Stable Transformation, LLC* 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 *Stable Transformation, LLC*. 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)

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Release of Information Contract

Client's Name:_____ Date of Birth:_____ Age:_____
Parent/Guardian Name:_____
I hereby authorize *Stable Transformation, LLC***.** to release and/or exchange protected health information for the above stated client for the duration of services received from *Stable Transformation, LLC*. 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:

___ Admission Assessment	___ Substance Abuse Info	___ Mental Status
___ Evaluation	___ Discharge Plan	___ Diagnoses
___ Progress Notes	___ Psychological Records	
___ Court/Agency Documents	___ Communicable Disease	___ Educational Records

___ 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), and the federal drug and alcohol confidentiality law (42 C.F.R. part 2)

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 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 this law.

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 *Stable Transformation, LLC.*, 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

Stable TRANSFORMATION
PSYCHOTHERAPY FOR PEOPLE USING HORSES

Stable Transformation, LLC.
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 *Stable Transformation, LLC.* to anyone who is not affiliated with *Stable Transformation, LLC*. This confidentiality agreement is effective the date of the signing of this agreement, and is forever binding after my association with *Stable Transformation, LLC*, ends.

Equine Liability Release and Risk Acknowledgement:

1.Parties. The parties to this document are Stable Transformation, LLC (hereinafter "Stable Transformation") 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 Stable Transformation, or be present on the property on which Stable Transformation conducts its activities, client does agree to hold harmless and release Stable Transformation, its officers, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on Stable Transformation's behalf and the owner(s) of any horse or other property used by Stable Transformation, 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 Stable Transformation, 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 Stable Transformation or client's presence on or proximity to property used by Stable Transformation.

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 Stable Transformation 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 Stable Transformation 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 Stable Transformation constitutes a knowing and voluntary assumption of all risks associated with equine activities involving Stable Transformation or being present on or using Stable Transformation property (including but not limited to inherent risks and the risk of negligence by Stable Transformation or others.

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. Stable Transformation 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 Stable Transformation any person who is not a party to an Equine Activity Liability Agreement with Stable Transformation, 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 Stable Transformation safety rules or the directions of Stable Transformation'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 Stable Transformation’s officers, directors, shareholders, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on Stable Transformation’s behalf and the owner(s) of any horse or other property used by Stable Transformation. This agreement shall be binding upon Stable Transformation, 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 Stable Transformation at the address above. The Metropolitan General Sessions Court of Nashville-Davidson County shall be the exclusive venue for any litigation between client and the parties described above.

Warning

Under Tennessee Law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Tennessee Code Annotated, title 44, chapter 20.

_____ _____

Client Signature Date

_____ _____

Signature of Client's Parent/Guardian Date

Stable Transformation, LLC.
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. Please Read Carefully.

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 it be orally, on paper, 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 our 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, Stable Transformation originates and maintains health records describing my health history, symptoms, examination on test results, diagnosis, treatment, and any plans for future care of treatment for up to seven years after the date of my last session at Stable Transformation. 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 for 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 Stable Transformation, LLC. 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 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, Stable Transformation will charge you fifty cents ($.50) per page. You must submit your request in writing and in person to Stable Transformation, LLC., 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 to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for Stable Transformation. To request an amendment, your request must be made in writing and submitted to Stable Transformation, LLC., 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. Stable Transformation reserves the right to change their notice and practices and if the terms do change, you may obtain a revised Notice by contacting Stable Transformation, LLC. by mail or by asking a 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) Stable Transformation, LLC 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 Stable Transformation, 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. Stable Transformation, LLC. 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 Stable Transformation, LLC.

Stable Transformation, LLC.
1208 17th Ave South

US Dept. of Health and Human Services
200 Independence Ave., S.W.

Nashville, TN 37212
Telephone: (615) 689-0191

Washington, DC, 20201
Telephone: (202) 619-0257
Fax: 1-877-696-6775

Website: www.hhs.gov/

Stable TRANSFORMATION
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Stable Transformation, LLC.
Client Rights and Responsibilities

Client Rights

- 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 Stable Transformation 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.
- 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 of 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 Stable Transformation staff and outside representatives of his/her choice, free from restrain, 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 Stable Transformation, LLC.
- To have the assurance of confidential treatment of his/her clinical records and may approve or refuse their release to any individual outside Stable Transformation, 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

- To keep appointment or notify Stable Transformation, LLC. of necessary cancellations 48 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. Stable Transformation, LLC. has a sliding fee scale based on family income.
- To inform Stable Transformation, LLC. 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 Stable Transformation, LLC. staff member.
- To respect the privacy, safety, and property of others, he/she may come in contact with at Stable Transformation.

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 Stable Transformation, LLC. by mail at:
1208 17th Ave South, Nashville, TN 37212

Stable TRANSFORMATION
PSYCHOTHERAPY FOR PEOPLE USING HORSES

Stable Transformation, LLC
Policies & Consent for Treatment

General Payment Policy: *Stable Transformation, LLC*. offers two options for payment: private pay (cash, check or credit card), private insurance through a superbill given to you. A payment plan is available upon request and payment must be made in full by the date of service. There is a $35 service charge on all returned checks.

Delinquent Payments: **If account balances, for either services or no shows/late cancels, remain unpaid for 30 days, you agree to have your credit card charged to pay the full balance plus an additional $3.00 for the credit card processing fee.** A collection agency and/or the courts may be used in the event of a delinquent payment, and such an action could require that Paige Holliman, M.Ed., LPC/MHSP release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. There will be a 33.33% collection charge added to your balance and you are responsible for any other costs incurred from the collection agency or from attorneys.

Charges for Phone Consultation: Appointments should be scheduled for extended conversations or questions. Brief consultations will not be charged so long as they are 15 minutes or less.

Consent for Release of Information: In some cases *Stable Transformation, LLC* 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 *Stable Transformation, LLC* 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. 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 cannot 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 forty-eight (48) hours of your appointment time. Please make every effort to avoid canceling your appointment within forty-eight (48) 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 cannot be submitted to your insurance company for reimbursement. Late cancellation charges should be paid upon receipt of notice of late cancellation.

Release of Medical Information to Clinical Contracts or Stable Transformation, LLC Clinical Employees: By signing this agreement you are granting full consent for release of information to any other *Stable Transformation, LLC* 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.

Stable
TRANSFORMATION
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Stable Transformation, LLC
Policies & Consent for Treatment

2 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.

.

Reduced Fee 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 Stable Transformation LLC
- 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 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 *Stable Transformation, LLC.*

(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

