



Unbridled Change Client Registration Packet

Child's Name _____

Parent/Legal Guardian Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone # _____ Alt. # _____

Address _____

Child's Age: _____ Date of Birth _____ Gender Male Female

School _____

Referred by _____ Title _____

PHOTO RELEASE

I consent to and authorize the use and reproduction by Unbridled Change of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional material, educational activities, exhibitions of for any other use for the benefit of the organization.

Client's Signature: _____ DATE _____

Parent/Guardian & Title: _____ DATE _____



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Medical History, Emergency Information, & Health Care Consent (page 1 of 2)

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: _____



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Medical History, Emergency Information, & Health Care Consent (page 2 Of 2)

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 *Unbridled Change* 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 *Unbridled Change* 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 *Unbridled Change* 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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Consent Release of Information

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

I hereby authorize *Unbridled Change* to release and/or exchange protected health information for the above stated client for the duration of services received from *Unbridled Change* 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 *Unbridled Change*, 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 _____ Date



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

Equine Liability Release and Risk Acknowledgement:

- 1. Parties.** The parties to this document are *Unbridled Change* 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 *Unbridled Change*, or be present on the property on which *Unbridled Change* conducts its activities, client does agree to hold harmless and release *Unbridled Change*, its officers, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on *Unbridled Change's* behalf and the owner(s) of any horse or other property used by *Unbridled Change*, 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 *Unbridled Change*, 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 *Unbridled Change* or client's presence on or proximity to property used by *Unbridled Change*.
- 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 *Unbridled Change* 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 *Unbridled Change* 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 *Unbridled Change* constitutes a knowing and voluntary assumption of all risks associated with equine activities involving *Unbridled Change* or being present on or using *Unbridled Change* property (including but not limited to inherent risks and the risk of negligence by



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Unbridled Change or others) which is a defense under Virginia 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. *Unbridled Change* 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 *Unbridled Change* any person who is not a party to an Equine Activity Liability Agreement with *Unbridled Change*, 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 *Unbridled Change* safety rules or the directions of *Unbridled Change*'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 *Unbridled Change*'s officers, directors, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on *Unbridled Change*'s behalf and the owner(s) of any horse or other property used by *Unbridled Change*. This agreement shall be binding upon *Unbridled Change*, 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 *Unbridled Change* at the address above. The General Court of Justice Franklin County, Virginia shall be the exclusive venue for any litigation between client and the parties described above.

Client Signature

Date

Signature of Client's Parent/Guardian and title

Date



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CONSENT FOR DATA TO BE USED IN RESEARCH STUDIES

Unbridled Change 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 *Unbridled Change*, 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