Flyin’ Changes Equine Assisted Therapy
Intake Packet

MISSION STATEMENT
Flyin’ Changes Ranch seeks to provide a rich growing environment by providing therapeutic and horsemanship activities to the community. We believe building positive relationships with others through the horse can help to create new beginnings, provide healing and develop stronger support systems for the individual. Our vision is to continue to develop an environment that opens minds and hearts to new possibilities and encourages lasting changes.

PROGRAM INFORMATION
Equine-Assisted Psychotherapy (EAP):
Flyin’ Changes Equine Assisted Therapy provides horse facilitated activities that help youth and children improve mental health and behavioral issues. Programs are designed to foster positive social interactions, increase self-esteem, and help youth and children work through emotional struggles through providing a structured environment that encourages trust, communication, and overcoming challenges through the use of a horse. Chrisy Parrish, LMHCA is a certified CHA riding instructor and Mental Health Counselor Associate who has a passion for utilizing the power of the horse to foster positive changes.

How does Equine-Assisted Learning Work?
Through the use of the horse, staff seek to help clients through learning opportunities that foster growth. You don't necessarily ride the horses each time, you may groom them, lead them or play games with them on the ground. Through structured classroom, riding and ground activities, the horses can give you immediate feedback about yourself by mirroring your emotions and your behavior as well as encourage you to challenge yourself and overcome fears. This therapeutic activity is designed to address: self-awareness, self-esteem and personal confidence, communication, interpersonal effectiveness, trust, behavioral issues, limit-setting, and group cohesion.

What makes a horse so important?
Horses are big, curious, playful and can be intimidating, but they are amazingly beautiful and can captivate the attention of even the smallest child. Horses respond immediately and challenge us to be authentic. Horses don't lie and can tell when we do. They know if you mean what you say because they are social animals and can read body language very well. Humans feel rewarded and challenged when in the presence of a horse.

BEFORE ATTENDING
We ask that you complete all registration paperwork and review the orientation packet before attending your first session. Please remember to wear proper clothing and footwear for your safety. Appropriate clothing includes closed shoes with a low heel such as boots or sneakers, jeans or sturdy pants, and jacket if appropriate for the temperature that can get dirty/dusty. For your safety, please do not wear loose jewelry (necklaces, earrings, etc) that could become caught. Sun block should be worn in the warmer seasons and it is a good idea to bring water to summer sessions. Flyin’ Changes is not responsible for any of your belongings left at the barn.

To protect the privacy of our clients we ask that you not visit the ranch without an appointment. If you would like to bring family or friends to meet the horses you may do so, but need to schedule a time with Flyin’ Changes so that a staff member can be present. You may contact: Chrisy Parrish, (360) 921-2341, info@flyinchangesranch.org

We look forward to working with you. Please let us know if we can provide any additional information.
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REGISTRATION FORM

Name:______________________________________________  Age:______

Address

City, State, Zip

Phone (H)____________________  (C)____________________ Is it ok to text? _____

Email Address: ___________________

Would you like to be on the Flyin’Changes email list? ______

Parents or Guardians:

Name:_____________________Relationship:________________Phone:_____________

Name:_____________________Relationship:________________Phone:_____________

Name of School Presently Attending:_________________________________________

Who is authorized to take this child home?

(please note that we will only release the child to those that are listed on this form)

Name:_____________________Relationship:________________Phone:_____________

Name:_____________________Relationship:________________Phone:_____________

Personal History:

Is this child currently in the care of a mental health professional? ____Please describe treatment history:

__________________________________________________________________________

__________________________________________________________________________

Any legal charges, history of abuse or assault? ____If yes, please explain

__________________________________________________________________________

__________________________________________________________________________

What triggers negative reactions? How are negative reactions exhibited?

__________________________________________________________________________

__________________________________________________________________________

Any other issues we should be aware of?

__________________________________________________________________________

__________________________________________________________________________

Goals for Treatment:

___Peer Interaction ___Social Skills ___Behavioral Improvements ___Other: Please List ______.

Please describe goals for treatment:_______________________________________________

_______________________________________________
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MEDICAL HISTORY AND RELEASE

Name:______________________________________________  Date of Birth:_______

Address_________________________________________________________________

City, State, Zip ____________________________________________________________

Phone (H)____________________  (W)___________________ (C) ________________

Sex: M / F    Height:____________  Weight:_____________          Tetanus Shot: Y[   ] N[   ]

Medications (Please list names and state side effects that may effect time with the horses, such as, whether the medication impacts balance, sensitivity to sunlight, etc)
_____________________________________________________________________

Is there any health reason to limit the client’s activities?   Please explain below:

Please check any areas of medical concern and explain in the Comments section:

<table>
<thead>
<tr>
<th>Areas</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Diagnoses</td>
<td>________________________</td>
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<tr>
<td>Auditory</td>
<td>________________________</td>
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<tr>
<td>Visual</td>
<td>________________________</td>
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<tr>
<td>Speech</td>
<td>________________________</td>
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<tr>
<td>A seizure disorder?</td>
<td>________________________</td>
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<tr>
<td>Allergies / Asthma</td>
<td>________________________</td>
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<tr>
<td>hay ____  bee stings ____ dust ____ mold ____ Does the client carry an epi pen? ____</td>
<td></td>
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<tr>
<td>Learning Challenges</td>
<td>________________________</td>
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<tr>
<td>Other</td>
<td>________________________</td>
</tr>
</tbody>
</table>

In Case of Emergency: Please Contact:

Name:_____________________Relationship:________________Phone:_____________

Name:_____________________Relationship:________________Phone:_____________

EMERGENCY RELEASE: In the event emergency medical aid/treatment is required due to illness or injury while participating, I authorize Flyin’ Changes Ranch to:
1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment. This authorization includes x-rays, surgery, hospitalization, medication and any treatment deemed “life saving” by the physician. This provision will only be invoked if the parent/guardian or emergency contact person listed cannot be reached.

I have read the above release, and permit Flyin’ Changes Ranch to act as stated above in an emergency and to contact the above emergency contacts.

_____________________________  ___________________________   ______________
Signed                          Printed Name                      Date
Professional Disclosure and Consent to Treatment

Professional Disclosure Statement for Chrisy Parrish, LMHCA:
This Professional Disclosure Statement is designed to present my credentials and approach to counseling as a requirement with Washington State Law.

About Equine Assisted Therapy: Equine Assisted Therapy is a therapeutic activity that incorporates horses in a session. An equine assistant can be present to assist with the horses during larger group sessions. Horses are unique creatures that can mirror our own patterns and behaviors. Most work with horses is done on the ground. There is not necessarily riding involved in each session. It is important to understand that therapy can bring up very deep emotional issues. Success in therapy depends to some degree on your desire for change and on your willingness to be honest with yourself, me, and the horse. Awareness of need, willingness to talk, curiosity and openness will assist you in obtaining maximum benefit from our sessions.

Formal Education and Training: I am a WA state approved Licensed Mental Health Counselor Associate working to complete licensure. I have a Master’s Degree in Mental Health Counseling from Walden University as of August 2012 and I hold a Bachelor of Arts Degree in Psychology and Sociology from University of Portland, which was completed June 2007. Major course work includes; abnormal psychology, substance abuse and addictions, couples counseling, social, culture, and diversity issues, and depression. My clinical background includes working with homeless youth and adults, addictions counseling and working with children with mental health diagnoses. I am currently completing licensure requirements under the supervision of Brad Petersen LMHC with ANLCC. A requirement of completing licensure includes supervision of counseling hours regularly.

Confidentiality: There is a legal privilege in the state of Washington protecting the confidentiality of the information that you share with me. As a professional, I can assure you that I strive to maintain the strictest ethical standards of confidentiality. There are legal exceptions to client confidentiality. The following situations are those in which the information you have shared with me may be shared with others:

- If you sign a Consent to Release Information form.
- If you are a minor, I may discuss with your parents or guardians some of the information from counseling. If you are a minor and a victim of a crime, I may testify at an inquiry concerning the crime.
- If you and your partner are both seeing me for couples counseling, I may, at my discretion, discuss information with your spouse that you have revealed to me, unless you specifically indicate that certain information is confidential.
- In the event of a medical emergency, information deemed necessary for treatment may be released.
- In the event of a threat of harm to oneself or someone else, if that threat is perceived to be serious, the proper individual(s) must be contacted. This may include the individual(s) against whom a threat is made. A counselor is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act.
- In the event of suspected abuse of a child, dependent adult or elder, proper authorities must be contacted. The abuse does not have to be personally witnessed by the counselor.
- If you register a complaint with the Washington State Department of Health, information will be released as requested or required by the State to resolve the issue.
- If ordered by a Judge or other judicial officers, information regarding your treatment must be disclosed.
- If an attorney in the State of Washington duly subpoenas your records, they will be released unless you file a protection order within 14 days of the subpoena.
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- In the event of a client’s death or disability, information will be released as authorized by the client’s personal representative or beneficiary.

Washington State Department of Health Contact Information:
In the event that you wish to file a complaint regarding your counseling services, you may obtain a list of or copy of the acts of unprofessional conduct listed under RCW 18.130.180. For more information:
http://www.doh.wa.gov/hsqa/HealthProfComp.htm

Your Rights as a Client: You have the right to refuse or discontinue counseling services and the right to choose a practitioner and treatment modality that best suits your needs. You may terminate therapy at any time. It is every client’s right to discontinue from counseling with or without notice to the treatment provider. However, I request notification and recommend one final meeting to discuss termination as well as counseling goals and progress.

Consultations: I regularly consult with other professionals regarding clients with whom I am working. This allows me to serve you better, gaining other perspectives and ideas that may help you reach your goals. These consultations are obtained in such a way that confidentiality is maintained. As a Counselor Associate, every session may be viewed as a learning opportunity and may be discussed in a learning environment with my supervisor Brad Peterson LMHC. At times, a session may be recorded, but only with prior explicit written permission from you. You may contact Brad Peterson at (360) 980-7906 if you have any questions.

Emergencies: If you feel you are a danger to yourself or to someone else, please contact the nearest emergency room, call 911, or the crisis line at 360-696-9560 or toll-free 1-800-626-8137.

Fees:
Fees are due in full 1 week before the start of each term, camp or session to hold your space unless alternative arrangements or payment plans are arranged. Due to the nature of the groups and camps, if you are unable to attend, you will not receive a refund. Refunds for missed individual sessions or groups may be given if you give at least 12 hrs notice. You will be charged for all missed sessions without notice given. *At this time, we are unable to accept insurance. If you require financial aid or scholarship, you may apply. To obtain a scholarship, a letter describing your needs may be required to procure scholarship funds. Funds are limited, so please apply early.

Consent to Treatment and Waiver of Liability:
The undersigned assumes the unavoidable risks inherent to all horse-related activities, including but not limited to bodily injury and physical harm to horse, rider and spectator. In consideration, therefore, for the privilege of riding and/or working and/or participating in activities around horses with Chrissy Parrish, the undersigned, does hereby agree to hold harmless and indemnify Chrissy Parrish, and further release her from any liability or responsibility for accident, damage, injury or illness to the undersigned or to any horse owned by the undersigned or to any family member or spectator accompanying the undersigned on the premises.

Consent to Treatment: My signature below indicates that I have been provided a copy of the required professional disclosure statement. I have read and understand the information provided and agree to receive counseling services from Chrissy Parrish, LMHCA.

Client Printed Name and Signature ___________________________ Date __________

Parent or Guardian Printed Name and Signature ___________________________ Date __________
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PAYMENT FORM

Client Name: ___________________________ Date: ____________

Parties responsible for fee for service payment (indicate % if applicable):

Name of Individual or Agency: ___________________________ Phone: __________ Address: ___________________________

Responsible for amount of (%) ____________ Weekly: ______ Full Term: _______

Name of Individual or Agency: ___________________________ Phone: __________ Address: ___________________________

Responsible for amount of (%) ____________ Weekly: ______ Full Term: _______

Payments Made:

Payment Method: Cash __ Check # _____ Credit/Debit # __________ Exp. Date __________

Weekly ________ Monthly ________ Full Term ________ Scholarship Funds ________

Amount Due ________ Date __________

SCHOLARSHIP INFORMATION

If you need assistance paying program fees, you may qualify for our Scholarship and Sliding Fee Programs. Because our funding is limited and we would like to help as many individuals as possible, participants are expected to pay as they are able. Assistance is awarded on the ability to pay and available funding. The funding for this scholarship program comes from donations made by our community, both private and corporate. If you feel that there are special circumstances that should be considered, please provide in writing on additional paper. You will be notified once a decision is made.

Reason for requesting financial assistance:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Household Information: Number of Adults living in Home: __________

# Dependent Children Living at Home ________ Ages: ____________________________

Employment: Are you currently employed? Yes ___ No ___ Is spouse employed? Yes ___ No ___

Income: Please list all sources of income, for example: Social Security Benefits, Medicaid, Disability, Insurance Benefits, Unemployment Insurance, Child or Spousal Support.

Monthly Net Income (after taxes) $ ________ Spouse’s Net Income (after taxes) $ ________

Other monthly income $ ________ Source __________________________

STAFF USE ONLY

Approved: _____ Assistance granted $___________ per _ Week _ Session

Denied: _____ Reason: __________________________
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AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize: ____________________________________________ to
release information from the record of: ____________________________
DOB: _________

The information is to be released to: Flyin’ Changes Equine Therapy for the purpose of
developing an equine assisted psychotherapy or equine assisted learning program for the above
named participant. The information to be released is indicated below.

☐ Medical History
☐ Physical Therapy evaluation, assessment and program plan
☐ Occupation Therapy evaluation, assessment and program plan
☐ Speech Therapy evaluation, assessment and program plan
☐ Mental Health diagnosis and treatment plan
☐ Individual Habilitation Plan (I.H.P.)
☐ Classroom Individual Education Plan (I.E.P.)
☐ Psychosocial evaluation, assessment and program plan
☐ Court or Probation documentation
☐ Other: ____________________________________________________

This release is valid for one year and can be revoked, in writing, at my request

Signature: ____________________________________________ Date: __________

Print Name: ______________________________________________

Relation to Participant: _______________________________________

Please send materials to:
Flyin’ Changes Equine Assisted Learning
11904 NE 314th ST
Battle Ground, WA 98604
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PHOTO AND LIABILITY RELEASE

PHOTO RELEASE: I hereby consent to and authorize the use and reproduction by Flyin’ Changes Ranch of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

I (Print Name)____________________________________________ have read the above release, and give Photo release for my child or consent for Flyin’ Changes Ranch to use Photos or other materials as listed above.

Signed ___________________________________________________________________
Printed Name ___________________________________________________________________
Date ___________________________________________________________________

LIABILITY RELEASE: I acknowledge the risks and potential risks of interacting with horses. However, I feel the possible benefits to my family or the child I care for 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 Flyin Changes Ranch, its instructors, therapists, volunteers and/or Employees for any and all injuries and/or losses I may sustain as a result of use of Flyin’ Changes Ranch property, equipment, or facilities while participating.

It is understood and agreed that The Equine Activity Liability laws of the State of Washington, § RCW 4.24.540, state among its statutory provisions that “an equine activity sponsor or an equine professional shall not be liable for an injury to or the death of a participant engaged in an equine activity.” WARNING OF INHERENT RISKS: Equine Activity is inherently dangerous and I understand: a) the propensity of the animal to behave in ways that may result in injury, harm, or death to persons on or around them; b) the unpredictability of the animal’s reaction to outside stimulation such as sounds, sudden movement, and unfamiliar objects, persons, or other animals; c) the possibility of collisions with other animals or objects; d) or the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within his or her ability.

I further understand that serious accidents occasionally occur from participation in equestrian activities, and that participants occasionally sustain mortal or serious personal injuries and/or property damage, as a consequence thereof. I am aware that an equine activity sponsor or an equine professional shall not be liable for an injury to or the death of a participant engaged in an equine activity and that no participant nor participant’s representative may maintain an action against or recover from an equine activity sponsor or an equine professional for an injury to or the death of a participant engaged in an equine activity per Washington State RCW 4.24.540 Limitations on Liability for Equine Activities. Knowing these risks, I hereby agree to assume these risks and to release and hold harmless all of the persons or entities mentioned above. It is further understood and agreed that this waiver, release, and assumption of risk is to be binding on my heirs, executors and assigns.

I AM VOLUNTARILY PARTICIPATING IN THESE ACTIVITIES WITH KNOWLEDGE OF THE DANGER INVOLVED AND HEREBY AGREE TO ACCEPT ANY AND ALL RISKS OF INJURY OR DEATH. It is understood and agreed that this agreement is to be binding upon myself, my heirs, executors and assigns under the laws of the State of Washington. I understand that this is a legal document. I have read and understood this release and understand all its terms. I execute it voluntarily and with full knowledge of its meaning and significance. I hereby assume all of the risks associated with equine related activities.

I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN FLYIN CHANGES RANCH AND ME.

I HAVE READ AND UNDERSTAND THE ABOVE:

Signed ___________________________________________________________________
Printed Name ___________________________________________________________________
Date ___________________________________________________________________

IF UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN MUST READ AND SIGN BELOW! I REPRESENT THAT MY CHILD IS CAPABLE OF PARTICIPATING IN THE ABOVE EQUESTRIAN ACTIVITY. I HEREBY RELEASE ANY CLAIM IN NEGLIGENCE OR BREACH OF CONTRACT I MAY HAVE ARISING OUT OF ANY INJURY DUE TO AN ACTIVITY IN WHICH MY CHILD WILL BE INVOLVED. IN THE EVENT ANY OF MY REPRESENTATIONS ARE INCORRECT, AND THAT REPRESENTATION CAUSES OR CONTRIBUTES TO ANY INJURY TO MY CHILD, THEN I FLYIN’ CHANGES RANCH, ITS OFFICERS, INSTRUCTORS, THERAPISTS, VOLUNTEERS, AND/OR EMPLOYEES HARMLESS FROM SUCH CLAIM, AND WILL DEFEND AND FLYIN’ CHANGES RANCH FROM ANY SUCH CLAIM.

Signature of Parent or Guardian ___________________________________________________________________
Printed Name ___________________________________________________________________
Date ___________________________________________________________________