Counseling Registration Form

CATALYSTFARM

Patient Information

Name/Nickname: _____ DOB: _____/_____/_____ Age: _____

Street: _____ City: _____ Zip: _____

Diagnosis: _____

Onset: _____

Precautions/Needs: _____

_____

Allergies: _____

Mobility: Independent Ambulation? ☐ Y ☐ N Assisted Ambulation? ☐ Y ☐ N Wheelchair? ☐ Y ☐ N

Referring Physician (if applicable): _____ Physician Phone #: _____

Physician Address: _____

Responsible Party, if applicable

Name/Relation: _____

Address, if different: _____

_____

Phone #: _____ home ☐ cell ☐ work ☐

Alt. Phone #: _____ home ☐ cell ☐ work ☐

Email Address: _____

Name/Relation: _____

Address, if different: _____

_____

Phone #: _____ home ☐ cell ☐ work ☐

Alt. Phone #: _____ home ☐ cell ☐ work ☐

Email Address: _____

Insurance

☐ Self Pay (you may skip this section if Self Pay) ☐ Insurance

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____/_____/_____ Insured's Address, if different: _____

Primary Insurance Policy

Insurance Company: _____ Provider Phone Number (on back of card) _____

Deductible? Y ☐ N ☐ Co-Pay? Y ☐ N ☐ If yes, amount: _____

Identification Number: _____ Group Number: _____

Secondary Insurance Policy

Insurance Company: _____ Provider Phone Number (on back of card) _____

Identification Number: _____ Group Number: _____

Authorization for Emergency Medical Treatment

Patient's Name: _____

Preferred Physician's Name: _____ Phone #: _____

Preferred Medical Facility: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, and the above cannot be reached, I authorize Catalyst Farm to:

1. Secure and retain medical treatment and transportation, if needed
2. Release participant records upon request to the authorized individual or agency involved in medical emergency treatment.

CONSENT PLAN

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is/are unable to be reached.

Consent Signature: _____ Date: _____

Patient or Parent/Legal Guardian

NON-CONSENT PLAN

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

Non-Consent Signature: _____ Date: _____

Patient or Parent/Legal Guardian

Patient or Parent Concerns

What therapy goals do you have? Please be as specific as possible. This will help us know what is important to you. Is there any other information you would like us to know?

Please place a check next to each service for which you would like to register

☐ Occupational Therapy ☐ Physical Therapy ☐ Counseling

☐ Speech and Language Pathology ☐ Other: _____

Special Requests (i.e preferred days and times, desired treatment methods, etc):

Acknowledgement of Public Setting

CATALYSTFARM

Your privacy is of the upmost importance to us here at Catalyst Farm. Your Protected Health Information (PHI) will only be shared with the appropriate personnel (including, but not limited to, therapists, office staff and volunteers) in order to best serve your needs during sessions.

It is important to note that Catalyst Farm is located on public property and that visitors may be present during your therapy session. Your PHI will never be shared with these visitors, though they may see you on the property as you participate in sessions. We make every effort to ensure that visitors at the farm do not interfere with therapy.

I acknowledge that Catalyst Farm is located on public property. I understand that, while my PHI will be kept confidential, visitors of the farm may be present on the property during my therapy session.

_____

Patient's Name

_____ _____

Name of Parent/Guardian, if applicable Relationship to Patient

_____ _____

Signature of Patient or Parent/Guardian Date

Payment Policy

Payment is required at the start of each session. You may choose to keep a credit card on file. In order to do so, you must complete the credit card authorization form. When needed, you will receive monthly invoices from our billing company, Signature Billing Solutions. Unpaid invoices may result in discontinuation of services.

Insurance Billing: When billing insurance, patient is responsible for payment of services not covered by their insurance plan. We make our best effort to ascertain what services will and will not be covered prior to starting treatment and will alert family to any uncovered services as we become aware of them.

Payment Methods: We accept all major credit cards, checks and cash. Credit card payments may be made in person, over the phone or via Square online payment.

Conduct of Participants

We understand that some of our clients are working on learning appropriate social interactions and we are prepared to work through behavioral issues when necessary. Violence towards therapists, other patients, staff, volunteers, or animals may result in discharge from our program.

Cancellation of Appointment

We understand all too well that life sometimes gets in the way of appointments. We ask that you please notify us as soon as you know you cannot make your appointment. There is no cancellation fee. If cancellations become a habit, it may be grounds for discharge.

No Show

In the event of a “no show” for a scheduled therapy session, the client will be provided with an invoice for $50 to be paid upon receipt.

Weather Related Cancellations

Summer: For the safety of our patients and horses, Hippotherapy sessions will be cancelled when the heat index is 90 degrees or higher. A farm-based or traditional session will be held in it’s place.

Winter: If road conditions are such that it is unsafe to drive, sessions will be cancelled. You will receive a call or text message alerting you to the cancellation.
Please note, we have heated indoor spaces and our barn is heated to 40 degrees. Therefore, sessions are not cancelled due to low temperatures. However, if the barn temperature of 40 degrees is too cold to produce a beneficial effect from therapy (for example, causes increased muscle tone), sessions will be held in our indoor clinic space with limited time in barn, if any.

Please let us know if you have any questions or concerns regarding these policies.

_____ _____

Patient or Parent/Guardian Signature Date

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Catalyst Farm, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Details about how this information may be used can be found in our Notice of Privacy Practice document.

By signing this form, I understand that:

- Protected Health Information (PHI) may be disclosed or used for treatment, payment or healthcare operation.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice may condition receipt of treatment upon execution of this consent.

May we leave a message on your answering machine regarding your appointments?

Cell Phone: yes ☐ no ☐ Home Phone: yes ☐ no ☐

May we email your specified email address with your PHI, including assessment results and appointment details?

yes ☐ no ☐

May we text appointment reminders to your cell phone? yes ☐ no ☐

Preferred communication methods regarding scheduling and other general questions: call ☐ text ☐ email ☐

May we discuss your PHI with other members of your family? yes ☐ no ☐

If yes, please list below:

_____ Name/Relationship

_____ Name/Relationship

_____ Name/Relationship

_____ Name/Relationship

_____
Name of Patient

_____
Name of parent/legal guardian completing form, if applicable

_____
Relationship to Patient

_____
Signature of patient or parent/legal guardian

_____
Date

Acknowledgement of Receipt of Notice of Privacy Practices

CATALYSTFARM

Patient Name: ___________________________________

I hereby acknowledge that I have been provided a copy of Catalyst Farm's Notice of Privacy Practices (available at clinic and online at www.catalystfarm.com).

I understand that I am not required to sign this for in order to receive services from Catalyst Farm, LLC

______________________________	______________
Signature of Patient or Legal Representative	Date
______________________________	______________
Printed Name of Patient's Representative	Relationship to Patient

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices on the following date, ___________________________________, but acknowledgement could not be obtained due to:

___ Patient/representative refused to sign

___ Communication barriers prohibited obtaining acknowledgement (Explain)

___ Other (Specify)

LIABILITY RELEASE FORM

This form must be completed by and for each party wishing for access to the premises

This Form is executed by the undersigned in favor of the Catalyst Farm, LLC, an Ohio limited liability company (the "Catalyst Farm"), whose business address is at 1021 Ridgewood Road Wadsworth, Ohio 44281 (the "Premises").

Catalyst Farm operates a farm based therapy practice, which may include an interactive animal experience and activities on horseback, on the Premises and maintains the Premises in its natural condition, as affected by activities thereon.

Because of the inherent and natural risk of harm that may occur to an individual in close proximity to animals (including horses) and their habitat, Catalyst Farm restricts access to the Premises to its agents and customers.

The undersigned desires access to the Premises for one or more commercial or personal purposes and understands that Catalyst Farm would not permit such access without the undersigned's acknowledgment of such risks and agreeing to release Catalyst Farm from such risk.

PLEASE READ CAREFULLY BEFORE SIGNING

SERIOUS INJURY MAY RESULT FROM A PERSON'S ACCESS TO THE PREMISES AND CATALYST FARM IS NOT RESPONSIBLE FOR AND DOES NOT GUARANTEE ANY PERSON'S SAFETY ON THE PREMISES. THE UNDERSIGNED HEREBY ACKNOWLEDGES AND AGREES THAT:

A. The undersigned hereby voluntarily requests access to the Premises.

B. This agreement shall be legally binding upon the undersigned and its heirs, estate, assigns, successors, agents, guests and invitees and shall be governed and interpreted according to the laws of Medina County, Ohio.

C. Horseback riding is classified as RUGGED ADVENTURE RECREATIONAL SPORT ACTIVITY and that there are numerous obvious and non-obvious inherent risks always present in such activity despite all safety precautions. According to NEISS (National Electronic Injury Surveillance Systems of United States Consumer Products) horse activities rank 64th among the activities of people relative to injuries that result in a stay at U.S. hospitals. Related injuries can be severe, requiring more hospital days and resulting in more lasting residual effects than injuries in other activities.

D. 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 rider falls from a horse to ground it will generally be at a distance of from 31/2 to 51/2 feet, and the impact may result in injury to the rider. Horseback riding is the only sport where on much smaller, weaker predator animal (human) tires to impose its will on and become on unit of movement with, another much larger, stronger prey animal with a mind of its own (horse) and each has a limited understanding of the other. If a horse is frightened or provoked it may divert from its training and act according to its natural survival instincts which may include, but are not limited to: stopping short, changing directions or speed at will; shifting its weight; bucking; rearing; kicking; biting; or running from danger. No farm animal is completely safe and may also exhibit the above mentioned behaviors.

E. For the benefit of the animals on the Premises, Catalyst Farm attempts to maintain the Premises in as much a natural condition as possible, as affected by activities occurring thereon.

F. Catalyst Farm is NOT responsible for total or partial acts, occurrences, or elements of nature that can scare a horse or other farm animal, cause it to fall, or react in some other unsafe way. SOME EXAMPLES ARE: thunder, lightening, rain, wind, wild and domestic animals, insects, reptiles, which may walk, run, fly near, bite and/or sting a horse/farm animal or person; and irregular footing on out-of-door groomed or wild land which is subject to constant change in condition according to weather, temperature, and natural and man-made changes in landscape.

G. The undersigned has inspected the Premises and is satisfied that all conditions of the Premises are safe for its access thereto.

H. Any medical treatment that results from the undersigned's access to the Premises shall be the undersigned sole responsibility.

I. In consideration of Catalyst Farm allowing access to the Premises by the undersigned, the undersigned shall hold harmless, indemnify and hereby releases Catalyst Farm, its owners, agents, employees, officers, members, premises owners, insurers, and affiliated organizations from any claims arising out of the undersigned's access to the Premises.

J. Under Ohio Revised Code Section 2305.321, it is expressly understood that the undersigned knowingly and voluntarily assumes any and all risks of harm or injury which are inherently involved in riding, working with, and being around farm animals, including horses. These risks include damage to personal property, illness, bodily injury, trauma or death that may result to a person from a fall while riding or being in close proximity to horses/farm animals. This Agreement extends to any harm or injury which a person may suffer from (1) their use of the property, facilities, equipment, tack and/or any horse/farm animal on the Premises, and (2) the risks of injury or damage which may be caused by, result from or be incidental to the person's engaging in any and all equine or horse/farm animal related activities while the person is on the Premises, or participating in any horse show, exhibition or clinic, or under supervision, direction or instruction by the Stable's owner, representatives, agents, instructors or employees.

This Assumption of Risk is intended and is understood to include, but not limited to each of the following inherent risks of harm:

1. The propensity of any horse/farm animal to behave in ways that may result in serious injury, death or loss to the rider or persons on or around the horse/farm animal;
2. The unpredictability or the reaction of any horse/farm animal to sounds, sudden movement, unfamiliar objects, persons or other animals;
3. Hazards, including but not limited to surface or subsurface conditions;
4. A collision with another horse, another animal, a person or an object;
5. The potential of a person who is engaged in any activity with a horse/farm animal to act in a negligent manner that may contribute to serious injury, death, or loss to the rider or to another person including but not limited to a person failing to maintain control over a horse/farm animal or failing to act within their actual or perceived ability to do so.

K. Receiving therapy services at Catalyst Farm does not guarantee desired results.

SIGNER STATEMENT OF AWARENESS

I/WE, THE UNDERSIGNED, HAVE READ AND DO UNDERSTAND THE FOREGOING AGREEMENT, WARNINGS, RELEASE AND ASSUMPTION OF RISK.

_____
Name (Please Print)

_____ _____
SIGNATURE Date

_____ for _____
SIGNATURE OF PARENT, or GUARDIAN (Please Print name(s) of minors)

_____
(names of minors continued)

DATE_____

Address in full:_____

_____

Home Phone #:_____ Cell Phone #_____

Email:_____

Photo Release (optional)

I, _____, authorize and consent to the use of my visual image, as well as my family members listed below, by Catalyst Farm for appropriate purposes, including, but not limited to: still photography, videotape, electronic and print publications and websites. I give this consent with no claim for payment.

1. _____
2. _____
3. _____
4. _____
5. _____

_____ _____
Signature Date

Phone Number (in case we need to contact you):_____

CATALYSTFARM

Your Counselor adheres to the following Patient Rights and Responsibilities as related to the patient's care.

PATIENT RIGHTS

♦ Patients have the right to quality services, appropriate to their health care needs, which are delivered in a timely manner.
♦ Patients have the right to appropriate medically necessary medical care.
♦ Patients have the right to reasonable access to medical care.
♦ Patients have the right to confidentiality in regard to medical and social history, individual medical records and medical information.
♦ Patients have the right to be treated with dignity, respect and consideration.
♦ Patients have the right to be informed about personal health as it concerns medical conditions, diagnostic tests and treatment plans.
♦ Patients have the right to change providers.
♦ Patients have the right to a second opinion.
♦ Patients have the right to involvement in decision-making concerning treatment.
♦ Patients have the right to approve or refuse the release of information except when the release is required by law.
♦ Patients have the right to refuse treatment or therapy. Such persons will be made aware of the consequences of their decision and it will be documented in their medical record.
♦ Patients have the right to refuse the incorporation of an animal in a treatment intervention.
♦ Patients have the right to assert complaints and grievances about the providers and the health care provided.
♦ Patients have the right to be informed about the role of medical students/supervised practitioners and the right to refuse such care.

PATIENT RESPONSIBILITIES

♦ To become informed about their insurance plan including benefits available.
♦ To become knowledgeable of the system to access medical care.
♦ To keep all scheduled appointments and to notify the provider when unable to keep a scheduled appointment.
♦ To be on time for all scheduled appointments
♦ To follow all medically appropriate physician orders and prescriptions.
♦ To treat all personnel with courtesy and respect.
♦ To provide complete health status information for accurate diagnosis and appropriate treatment.
♦ To notify your counselor when you receive emergency mental health care within twenty-four (24) hours, or as soon as possible.

Signature of Patient or Parent/Guardian:_____ Date:_____

Thank you for choosing Catalyst Farm, LLC! We are dedicated to assisting you with your concerns and promoting your personal growth. To assist in this process the following information is listed for your reference.

1. Megan Miksch, LPC engages in the diagnosis and treatment of mental and emotional disorders under the supervision of Amanda Cole, LPCC-S.

2. Kimberly Steppenbacker, LPC engages in the diagnosis and treatment of mental and emotional disorders under the supervision of Amanda Cole, LPCC-S

3. Jacquelyn Kolenz, M.A, A.T.R., LPC engages in the diagnosis and treatment of mental and emotional disorders under the supervision of Amanda Cole, LPCC-S.

4. Amanda Cole, LPCC-S engages in the diagnosis and treatment of mental and emotional disorders.

5. Currently, individual counseling sessions are scheduled at times that are jointly convenient for both the patient and Counselor.

6. For Self-Pay clients, Initial evaluations are charged at a rate of $150 and individual 60 minute self pay sessions are charged at a rate of $90 per professional hour (60 minutes). This information is required by the Counselor, Social Worker, and Marriage and Family Therapist Board, which regulates the practices of professional counseling, social work, and marriage and family therapy in this state.

   Ohio Counselor, Social Worker, and Marriage and Family Therapist Board
   77 High Street
   Columbus, OH 43215
   PH: 614-466-0912

7. We require your payment at the time of service and accept check, cash, and credit.

8. We complete and file all insurance claims for primary insurance. While we extend this service as a courtesy, you are ultimately responsible for the account. In the event of specific custody regarding minor children, the individual signing this Office Procedure is ultimately responsible for the account. In the case of blended families, custody paperwork must be brought in at the initial visit.

9. If you need to contact Megan Miksch, LPC or Amanda Cole, LPCC-S outside of normal session hours please call 234-206-0815 and leave a message, including your phone number; or email counseling@catalystfarm.com. Please keep in mind that this is not an emergency number or email and in the case of an emergency, call 911 or go to the nearest emergency room. Voicemail messages will be checked regularly and phone calls will be returned at the earliest possible time. Email will only be regularly checked Monday through Friday between the hours of 8:30 am and 6:30 pm. Please contact Megan and Amanda via phone (at the number above) for any nonemergency, clinical concerns.

10. If you need to cancel or reschedule a session, please do so with as much notice as possible.

11. It is the responsibility of the client, or the client's parent/guardian, to keep the office updated with correct insurance information. Failure to do so could result in the client, or client's parent/guardian, being totally financially responsible for all services provided.

STATEMENT OF CONFIDENTIALITY

Any and all information and/or records that we have about you are kept in the strictest confidence. Your confidentiality is protected by law and by standards of good practice. Under normal circumstances, we can release information about you only if you have completed, signed and dated authorization documents. Please keep in mind that counseling sessions can take place at different locations on the farm and your child may be viewed or overheard by individuals frequenting the property. All efforts will be taken to ensure the confidentiality of your child during counseling sessions, but due to the farm environment there are limitations to this. If this if a concern for you, you have the right to request more traditional sessions in a confidential, private area, but note that the ability to incorporate animal involvement in these sessions will be restricted. Law and standards of good practice allow us to disclose

information without your authorization under the following circumstances:
• Client is a risk to him/herself or other(s).
• We suspect child/elder abuse or neglect.
• Medical personnel request information during a medical emergency.
• Disclosure is required under court order.
• Client commits a crime against a staff member or property of our practice.

POSSIBLE RISKS OF TREATMENT

As a consumer of psychotherapy you may notice an increase in symptoms or experience some level of anxiety, depression, somatic concern, or other discomfort. If any of these symptoms present themselves, please discuss them with your counselor. Please review our Liability Release form to review possible risks associated with animal assisted therapy.

TREATMENT OF MINORS

Minor children are not seen at this facility without the written consent of their parent or guardian. When an appointment is scheduled, it is determined that a parent/guardian must accompany the child/adolescent for the first visit to give written consent. **In the event of specific custody regarding minors, the individual signing this Office Procedure is ultimately responsible for the account.** In the case of blended families, custody paperwork must be brought in at the initial visit. Clinicians actively encourage ongoing involvement of parents or guardians in the treatment of minor children and adolescents.

AUTHORIZATION TO FILE INSURANCE/FINANCIAL RESPONSIBILITY STATEMENT

I hereby authorize said assignee to release only information necessary to secure the insurance payment. I hereby assign all medical benefits, including any major medical benefits to which I am entitled including private insurance, and any other health plans to: Catalyst Farm, LLC. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I have read and understand all the above information.

_____ _____
Signature of Patient Date

_____
Printed Name of Patient

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

I, _____, parent or court appointed guardian (please circle one), give my permission for the below mentioned therapists to treat my minor child(ren).

Megan Miksch, LPC
Kimberly Steppenbacker, LPC
Jacquelyn Kolenz, M.A., A.T.R., LPC
Amanda Cole, LPCC-S

Name(s) of child(ren): _____

_____ _____
Signature of Parent/Guardian Date