PROJECT HORSE
EMPOWERMENT CENTER

Client Services Agreement

Welcome to Project Horse and thank you for choosing our equine assisted practice. We are committed to providing the very best equine assisted therapy and/or experiential learning experiences possible to each and every client. To help ensure this, it is important that you are aware of our professional service guidelines, business policies and expectations about the responsibilities of all involved parties, including our treatment team.

SERVICES

Therapy and/or experiential learning sessions can vary from weekly, to bi-weekly, to monthly, to an occasional check-in or adjunct session. Typically, to get started, sessions are held once weekly, like in a traditional office setting. The initial few sessions will be an evaluation of needs, along with possible recommendations. Treatment goals will be created that will be reasonable to achieve in our equine assisted setting, in order to best address client (or parent) concerns. If the client has a primary therapist – once a **Release of Information** is put in place by the client – our treatment staff will have contact as needed with the primary therapist in order to collaborate on approach, report on progress, and otherwise share pertinent treatment-related information.

CLIENT RESPONSIBILITIES

- Provide accurate information about past illness, hospitalizations, medications, family history, lifestyle habits and behaviors.
- Report new developments, current hospitalizations, new prescription medications and recent/new crises.
- Clearly understand the nature of our work together and ask for clarification when needed.
- Regular attendance to scheduled appointments and timely notice of rescheduling appointments.
- Follow through with treatment assignments and tasks.
- Payment of services on the day they are received.
- When children attend Project Horse, either as part of a session or waiting as a sibling, they must be supervised by an adult at all times. This is paramount to ensure their safety as well as respect the privacy of other organizations and individuals on the property.
- There must be a signed **Release Waiver** on file for every client and accompanying family member, guardian or caregiver. This must be provided no later than the first visit to Project Horse and can be mailed, faxed, emailed or presented in person.
- There must be a current and signed **Medical Consent Form** on file for every client. This must be provided no later than the first visit to Project Horse and can be mailed, faxed, emailed or presented in person.

CLIENT RIGHTS

As a client of Project Horse, you have the right:

- To be treated with dignity and respect.
- To be provided a description of the recommended treatment, including potential risks and benefits.
- To ask for clarification about our work, treatment process or policies.
- To specify and discuss therapeutic goals and be an active participant in therapy.
- To terminate therapy at any time. We will provide you with other referral sources upon request.
- To have confidentiality maintained under the laws of the Commonwealth of Virginia and HIPAA federal privacy practices. Additional information about confidentiality can be found below.

CONFIDENTIALITY

As a client, one of your most important rights is that of confidentiality. All information you provide will be treated confidentially and will not be disclosed to anyone outside of Project Horse without your written consent. There are exceptions to confidentiality as defined by state law and professional ethics. The instances in which confidential information can or must be released *without consent* are stated below. In those cases when information must be released *without consent*, every attempt will be made to notify you beforehand.

- If you pose a serious danger to yourself or others.
- If neglect or abuse of a child or adult is suspected. All Project Horse staff are mandatory reporters.
- If a court issues a subpoena concerning your records.
- If insurance requires a medical review of treatment services (applies only to therapy services).

SESSION APPOINTMENTS

Individual, couples, family or sibling therapy and/or experiential learning sessions are up to 55 minutes in length. If you need to cancel or reschedule any session appointments, you are required to give a 24 hour notice. Failure to give 24 hours' notice may result in being charged Project Horse's full session fee. If you arrive late to your appointment, your session will still need to end at the normal appointed time. Three (3) consecutive missed sessions or a frequent pattern of missed sessions may result in termination of services.

SESSION FEES

Payment is due at the time services are rendered. Acceptable methods of payment are cash, check and credit card, and a 3.3% processing fee is passed through when credit card is used for payment. A $50 fee will be charged for bounced checks. Outstanding balances, including missed session fees, will be submitted to collections after becoming 90 days past due. Please note that Project Horse does not participate in any insurance programs, and we are an out-of-network provider for Therapy Services. Experiential Learning / Wellness Services are not "therapy" and, as such, never qualify for coverage by medical or health insurance. However, depending upon your plan, you may be able to use a Flexible Spending Account (FSA) to pay for non-therapy services.

THERAPY SERVICES

Intake assessment session	billed to quarter hour, 1 hour minimum	$175/hour
Individual session	up to 55 minutes	$225/session
Family, couples, sibling session	up to 55 minutes	$275/session
Trauma-Focused Mounted session*	up to 55 minutes	$265/session

***Trauma-Focused Mounted Psychotherapy** is an individual service and augments the non-riding relationship-based equine assisted therapy services Project Horse has always provided. With this mounted intervention, clients are typically led around the arena on the back of a horse while engaging in guided bilateral stimulation exercises (to activate different levels of the brain). For some clients, the movement combined with bilateral stimulation significantly enhances their ability to emotionally regulate.

EXPERIENTIAL LEARNING / WELLNESS SERVICES

Intake assessment session	billed to quarter hour, 1 hour minimum	$150/hour
Individual session	up to 55 minutes	$175/session
Family, couples, sibling session	up to 55 minutes	$215/session

OTHER FEES & CHARGES

Missed Appointment / No-Show	full session fee
Late Cancellation (less than 24 hours' notice)	full session fee

Court Preparation & Appearance (minimum 3 hours billed) **$325/hour**
(If court is cancelled for any reason whatsoever with less than 36 hours' notice, you are still liable for the full minimum fee.)

EMERGENCIES / AFTER-HOURS

We do not offer on-call or after-hours emergency services. If you are experiencing an emergency that is not life threatening, please leave a detailed message on our confidential voice message system and you will receive a return phone call as soon as possible. In the event of a life threatening emergency, and you cannot safely await a return call, please call 911 or go to your local emergency room.

_____
(initials of client/parent)

TERMINATION

Therapy services and/or experiential learning services typically end after a mutual agreement about readiness as well as goal completion with maximized benefit. Our clients may always terminate services at any time. If you cancel or miss scheduled appointments and do not contact us for a period greater than 30 days, it is understood that you have terminated your treatment, and your case will be closed. Frequent missed sessions may also result in termination of services. Once treatment is terminated, our treatment team members have no further obligation to the client. If you have completed therapy and/or experiential learning services, and wish to resume at any point in the future, we will make every effort to accommodate your scheduling needs.

CLIENT INFORMATION

Client's Full Name: _____

Date of Birth: _____ **Gender:** _____

Address: _____

_____

Employer/School: _____

Age (if minor): _____ **Grade (if applicable):** _____

RESPONSIBLE PARTY

For and in consideration of services rendered, or to be rendered to the named client, I guarantee payment of all charges occurred in accordance with the policy payment of bills. In the event my account must be placed with an attorney or a collection agency to obtain payment, I agree that jurisdiction for said collection shall be Loudoun County, Virginia, and that I shall pay all allowable costs associated with attorneys, collections, court, and interest on the total unpaid balance at a rate of 1.5% per month. By signing below I indicate agreement to the terms of treatment as well as payment, as written above.

Guarantor's Name: _____ **Relationship to Client:** _____

Signature: _____ **Date:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____ **Ext.** _____

Email address: _____

Please circle YES for all of the ways you permit us to contact you *and* leave detailed messages for you:

Home Phone: YES / NO Cell Phone: YES / NO Email: YES / NO

REFERRED BY (name) : _____

☐ Therapist ☐ Guidance Counselor ☐ Doctor ☐ Friend ☐ Internet ☐ Other _____

Current Medications: _____

_____

Recent Diagnosis (include when diagnosis was made and by whom): _____

_____

_____

Environmental Allergies: _____

Food or Other Allergies: _____

Any other pertinent information you'd like us to know:

_____

_____

_____

CONSENT TO SERVICES

My signature below indicates that I have read the above agreement, including notice of fees, policies and privacy practices. I have had the opportunity to ask any questions to ensure I understand this agreement fully, and I willingly enter into this agreement with Project Horse, Inc. By checking below the one appropriate box below, I am consenting to the following service type and understand that I am selecting either a therapy service *or* a non-therapy/wellness service from Project Horse and its professional team:

☐ **Equine assisted therapy services** *(a licensed therapist is involved in sessions)*

–OR–

☐ **Equine assisted experiential learning services** *(therapist is not involved in sessions)*

_____ _____

Client's Full Name & Signature **Date**

_____ _____

Parent's Name & Signature (if client is under age 18) **Date**