Eagle Vista Ranch & Wellness Center 16150 Golden Eagle Court NW Bemidji, MN 56601
Email: eaglevistaranch@gmail.com Phone: (218) 760-0656 Fax: (218) 243-2900

CLIENT REGISTRATION

Client Name: _____
Client Age: _____ Date of Birth:_____ Gender: [ ] Male [ ] Female
Parent/Legal Guardian Name (if client is a minor)_____
Address: _____
City:_____ State_____ Zip_____
Cell:_____ Home:_____ Work:_____
Email Address: _____
Referred by _____ Title _____
School /Employer (if applicable): _____
Primary Insurance Provider: _____ Policy Holder: _____
Policy Holder D.O.B. _____ ID#_____ Group/Contact: _____
Secondary Insurance Provider: _____ Policy Holder: _____
Policy Holder D.O.B. _____ ID#_____ Group/Contact: _____
List any legal issues and/or charges (if applicable):_____

Medical History, Emergency Information, & Health Care Consent

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**
*Allergies/Asthma			
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Learning Disability			
Psychological Impairment			
Diabetes			
Other			

Medical History, Emergency Information, & Health Care Consent

Parent/Guardian, if minor:_____ Phone _____
Emergency Contact_____ Relationship:_____ Phone _____
Client's Primary Physician:_____Phone:_____

By signing this form, I certify all information to be complete and true to the best of my knowledge.

At this time, EVRWC is able to bill for select insurance providers and will take care of the paperwork for you. In the case that you are covered by an insurance provider that we do not bill for, we will be happy to assist you in submitting your claim or finding another therapist in the community to suit your needs. This does not guarantee coverage for our services. As such, co-payment and payment is due at the time of service in the form of cash or check. You are responsible as per Eagle Vista Ranch & Wellness Center Financial policy for payment balances on your accounts.

Payment: Cash, check and credit cards are accepted for payment.

Note: If you do not show up for your scheduled therapy appointment, and you have not notified us at least 24 hours in advance, you may be required to pay the full cost of the session.

Client Signature _____:_____Date:_____

Parent/Guardian signature, if minor):_____Date:_____

Notice of Privacy Practices - Eagle Vista Ranch & Wellness Center

Client's Name: _____ Date of Birth: _____

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY ELIZABETH A. LETSON, MS, LPCC/EAGLE VISTA RANCH & WELLNESS CENTER AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Information about you is collected by our staff of professionals for the purpose of providing services to you, including assessment, psychotherapy, and other mental health or chemical dependency treatment. Unless ordered by a court, you have the right to refuse to provide any information at any time. Refusing to provide information may make it more difficult for us to provide competent and effective services to you. Protected or private health information may be released to or obtained from any individual or organization of your choosing, provided you have given us your authorization in writing to do so. Your clinical record, or certain portions of it, may be provided to or used by the following individuals without your signed authorization:

- Any authorized staff in regards to billing, support staff, and clinical supervisors, on a need-to-know basis
- Health insurance provider
- Personnel from the Department of Human Services
- U.S. Secretary of Health and Human Services; or his designated representative
- We may provide certain information to an outside collection agency for the purpose of collection on an unpaid bill.

There are some additional situations in which we may have to share protected health information about you without your signed authorization:

- We are required by law to report suspected neglect, physical abuse, or sexual abuse of a child that has occurred in the past three years.
- We are required by law to report suspected maltreatment of vulnerable adults.
- We may report situations in which you are believed to be at risk of harming yourself or someone else in the immediate future.
- We may have to disclose information if required by a court order.

You have the following rights regarding protected health information about you:

- You have the right to request restrictions on certain uses and disclosures of protected health information about you, but this office is not required to agree to a requested restriction.
- You have the right to receive confidential communications of your protected health information.
- You have the right to inspect and copy protected health information about you contained in your clinical record. To do so, contact this office and inquire with your psychotherapist.
- You have the right to receive an accounting of disclosures of your protected health record.
- You have the right to amend, or request changes in, your protected health information.

Elizabeth A. Letson, MS, LPCC, has the following duties regarding protected health information:

- We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices concerning protected health information.
- We are required to abide by the terms of this notice.
- We reserve the right to change the terms of this notice whenever necessary and to make the provisions of the new notice effective for all protected health information that we maintain.

If you believe your privacy rights have been violated you are encouraged to file a complaint with the Secretary of Health and Human Services. Complaint forms are available through the Secretary of Health and Human Services.

IF YOU HAVE ANY QUESTIONS ABOUT OUR POLICIES AND PROCEDURES REGARDING OUR USES AND DISCLOSURES OF PRIVATE INFORMATION, PLEASE CONTACT: ELIZABETH A. LETSON, MS, LPCC at (218) 760-0656 or FAX: (218) 243-2900.

This notice is effective January 1, 2016. I have read and understand the above information:

_____ _____

Client Signature Date

_____ _____

Parent/guardian signature, if minor Date

Eagle Vista Ranch & Wellness Center

Elizabeth (Liz) Letson, MS, LPCC 16150 Golden Eagle Court NW Bemidji, MN 56601
Email: eaglevistaranch@gmail.com Phone: (218) 760-0656 Fax: (218) 243-2900

CONSENT AND RELEASE OF LIABILITY

I understand that working with, leading and riding horses are inherently dangerous activities and necessarily involve a high risk of loss of or damage or injury to equipment, horses, or people. By my signature below, and as a condition of my agreement to be part of the Equine Assisted Psychotherapy and Learning Session at Eagle Vista Ranch & Wellness Center, **I, _____(adult client or parent/guardian of a minor) hereby release Elizabeth A. Letson, Thomas Letson, and any employees, volunteers, or assistants of Eagle Vista Equine Center Inc. (dba: Eagle Vista Ranch & Wellness Center) from any liability to me or anyone claiming on behalf of me.**

I will be responsible for such loss, damage, or injury including, by way of illustration but not limitation, resulting from accidents or injury, to members of my family, friends, or guests and to those resulting from theft, loss of or damage to any buildings, equipment, horses, feed, vehicles, or trailers while on these premises and/or any trails upon which I will be working with, leading or riding. I will take all precautions necessary to insure the safety of myself, of other people, and of horses and equipment. I have also read and understand all of the above and will abide by it, voluntarily and intentionally signing this agreement.

Client voluntarily entering into the Equine Activity Agreement and Release of Liability:

Client Signature:_____ Date:_____

If the client is a minor, the parent or guardian of such minor acknowledges this Equine Activity Agreement and Release of Liability:
Parent or Guardian Signature:_____Date:_____

USE OF AGGREGATE DATA FOR RESEARCH
In order to determine the effectiveness of the program, summary data may be used in research. This may include scores on psychological tests or other questionnaires. Findings may be shared with other professionals through professional presentations or publication. **Any information that is used in research will be anonymous –no names or identifying information will be used.** Information will only be used at the aggregate level (ex. average scores). Your individual information will not be shared with anyone for research purposes.

By signing below, I consent to and authorize the use of my data for research purposes, to be reported at the aggregate level. I understand that no personal information will be shared and individual scores or responses will remain private.
Client's Signature: _____Date_____

Parent/Guardian:_____Date_____
Check here if you DO NOT ___ Consent and authorize Eagle Vista Ranch & Wellness Center to use your information for research.

Eagle Vista Ranch & Wellness Center

Therapist: Elizabeth Letson, MS, LPCC 16150 Golden Eagle Court NW Bemidji, MN 56601
Email: eaglevistaranch@gmail.com Phone: (218) 760-0656 Fax: (218) 243-2900

CONSENT & RELEASE OF INFORMATION

Client's Name:_____ Date of Birth:_____ Age:_____
Parent/Guardian Name/s: _____
I hereby authorize Eagle Vista Ranch & Wellness Center to release and/or exchange protected health information for the above stated client for the duration of services received from Eagle Vista Ranch with:
Name of Applicable Individual/Professional:_____
Organization:_____
Address/ City/State:_____
Office Phone:_____ Fax Phone:_____
The protected information to be released and/or exchanged may include the following:

___ Family/Social History ___ Substance Abuse Info ___ Medical Records
___ Evaluations/Reports ___ Discharge Plan ___ Diagnosis
___ Assessment/Treatment ___ Progress Notes ___ Psychological/Psychiatric
___ Court/Agency Documents ___ Educational Records ___ Diagnostic Assessment
___ 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: I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Eagle Vista Ranch & Wellness Center, will not deny or refuse treatment because of my refusal to sign.

_____
Signature of Client Date

_____
Signature of Parent/Guardian of Minor Client Date

_____
Relationship of Legal Guardian to Client