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Informed Consent for Equine Facilitated Psychotherapy Services

Welcome to the Equine Facilitated Psychotherapy (EFP) program. This is a document providing information about therapy services and your rights as a client/parent/caregiver. By signing this form, you are consenting to your family member/yourself meeting with the stated mental health professional for individual, group, or family therapy appointments. The goal of these sessions is to provide an opportunity for yourself/your family member to talk about any issues or problems they are experiencing that may affect their emotional, social, behavioral, and/or academic life. You have the right to participate in decision-making concerning you or your family member's therapy and there will be ongoing communication between you and the mental health professional.

Staff Credentials:

Angelique Saunders, MA, LPC has a Masters in Clinical Mental Health Counseling from Capella University and a B.A. in Psychology and Criminal Justice from The University at Albany. Her Master's degree focused on the study of trauma, substance abuse, and mood related disorders. Angelique holds a certificate as an Equine Specialist in Mental Health and Learning through the Professional Association of Therapeutic Horsemanship International (PATH Intl.). She is a Licensed Professional Counselor (#LPC.0018992) and Registered Psychotherapist (#NLC.0108730) in the state of Colorado.

Client Rights & Service Guidelines:

- You are entitled to receive information from the mental health professional about methods of therapy, the techniques used, the duration of your therapy (if known) and the fee structure.
- You can seek a second opinion from another therapist or terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder.
- I reserve the right to make referrals if I am unable to adequately assist you.
- Children may legally consent to their own treatment at the age of 15 and do not require permission from a parent/legal guardian.
- As an outpatient therapist in private practice, I do not provide on-call or emergency services. I will return all calls and emails within 24 hours, M-F. Should an emergency occur, please call 911 or call the Boulder County Crisis Line at (303) 447-1665.
- EFP sessions are held in a small and private field, arena, or in a round pen. Although there is an indoor arena we may use, it is often busy with other programs. In cases of inclement weather, you will have the choice of moving to an indoor office or the indoor arena if space is available. Complete privacy and confidentially cannot be guaranteed in the indoor arena.
- Clients are expected to dress appropriately for the weather and equine environment. I reserve the right to move therapy indoors, without a horse, should the client dress in a manner that is inappropriate or unsafe for the conditions.

***Privileged Communications**:*

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client or parent/guardian's consent. There are exceptions to this confidentiality, some of which are listed in section 12.43.218 of the Colorado Revised Statutes, as well as other exceptions in Colorado and Federal law. If a legal exception to confidentiality arises during therapy, if feasible, you will be informed accordingly. Exceptions to confidentiality include:

- If you or your child threatens to harm or cause the death of another person or themselves
- In the case of suspected child or elder abuse that may include neglect, assault, battery, or sexual abuse
- In the event that you or your child becomes gravely disabled or incapacitated
- If a subpoena, issued by a court of law, requests specific information related to counseling, that information must be provided
- In response to any legal action taken by you against this mental health professional
- If you request information to be given to another party and sign a release of information (ROI) document
- If I suspect a threat to national security
- Under CRS 14.10.123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information, we may provide you with a treatment summary in compliance with Colorado law.
- During the course of our work with you and the Colorado Therapeutic Riding Center, we would like your permission to provide information to relevant CTRC staff so that we can work together to maximize success and safety. Therefore, by signing this form, you are authorizing the mental health professional to share information obtained in therapy sessions and opinions formulated as a result with CTRC staff as needed.

Regulatory Requirements Applicable to Mental Health Professionals:
The agency that has the responsibility for licensed and unlicensed psychotherapists and counselors is the State Grievance Board with the Department of Regulatory Agencies, 1560 Broadway, Suite #1340, Denver, Colorado 80202, (303) 894-7766. If you have any concerns or complaints about your therapy, please contact the Grievance Board.

Payment for Services:
Payment is due at time of service. Cancellations require 24 hours' notice to avoid a fee. Without appropriate notice, missed sessions are to be paid in full at the regular rate. ***I currently only accept card, cash and check***. The following rates apply to all clients (per hour) that has been agreed upon prior to start of sessions (sliding fee scale available to clients with limited income):

- Individual session - $150
- Intake/Initial session - $175
- Returned check fee - $25
- Consultations and letters on your behalf - $75

____ I have read and agreed to the above payment for service responsibilities

By signing below, you are consenting to treatment through All in Stride Counseling, LLC. You are also stating that you have been provided with both written and oral information regarding your rights and therapist's credentials.

Client Name: ____ *Date:* ____________
(print) *(sign)*

Parent/Guardian Name: ____ *Date:* ____________
(print) *(sign)*

Parent/Guardian Name: ____ *Date:* ____________
(print) *(sign)*

Therapist Name: ____ *Date:* ____________
(print) *(sign)*