



Application and Rider Information
Jake's Flat Farm and Stables, LLC

Carolina Hoofprints

1454 Houston Mill Road
Conover, NC 28613

PERSONAL INFORMATION

RIDER/CLIENT

Name: _____

Birthday: _____ (if junior)

Address: _____

Email: _____

Tel: _____ (home) _____

(bus.)

Known medical problems: _____

Under any medication: _____

In case of emergency, contact: _____

Relationship: _____

Tel: _____ (home) _____ (bus.)

Doctor: _____

Tel.: _____ Hospital: _____

Medical Insurance _____ policy number# _____

RELEASE FROM LIABILITY

- I acknowledge that there are inherent dangers and risks in horseback riding and in being around or working with horses. I realize that I could be injured, maimed or killed while engaging in horseback riding or while being around or working with horses. I am prepared to take these risks. I release JAKE'S FLAT FARM AND STABLES,LLC, John Jaynes and Elisabeth Bliss-Jaynes, and CAROLINA HOOFPRIINTS from any and all liability or responsibility for any injury to myself

while riding on their premises, while riding a horse supplied by them, or while being around or working with or without a horse on their premises.

Under North Carolina law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina General Statutes."

Signature of parent or
Guardian _____

- I agree to indemnify JAKE'S FLAT FARM AND STABLES,LLC, John Jaynes and Elisabeth Bliss-Jaynes, and CAROLINA HOOFPRIINTS from any and all claims, demands, suits, or liability which may be brought against them by others as a result of injuries sustained by myself while riding on their premises, while riding a horse supplied by them, or simply while being around or working with a horse on their premises.
- I acknowledge it is my responsibility to wear protective headgear while mounted. It has been recommended to me that the protective headgear meet the A.S.T.M. (American Society for Testing Materials) standard and display the SEI (Safety Equipment Institute) seal.
- Jake's Flat Farm and Stables,LLC, and their employees and/or representatives make no representation or warranty expressed or implied about any protective headgear and cautions riders that serious injury and death may result despite wearing such headgear as all equestrian sports involve inherent risk and that no protective helmet can protect against all foreseeable injury.
- I acknowledge that it is my responsibility to wear appropriate footwear while on the premises of JAKE'S FLAT FARM AND STABLES,LLC. I will wear this footwear whether mounted or on the ground. This footwear will include shoes/boots and socks. Shoes or boots will have a flat tread sole, a 1" heel, and a fully enclosed upper. Boots or shoes designed for the purpose of equestrian activity are preferred but not required.
- I acknowledge that it is my responsibility to wear appropriate clothing which will include but not be limited to full length pants and minimal jewelry. I understand that JAKES FLAT FARM AND STABLES, LLC, and CAROLINA HOOFPRIINTS accept no liability for injury or damage to clothing/jewelry or injury caused by clothing/injury and reserves the right to request that I change clothing/jewelry that is deemed unsafe.

I ACKNOWLEDGE HAVING READ THE ABOVE RELEASE OF LIABILITY IN ITS ENTIRETY PRIOR TO SIGNING THIS FORM.

_____ Date _____
Rider

Natural/Custodial Parent or Guardian

Permission to Video and Photograph

Carolina Hoofprints, Jake's Flat Farm, LLC, and Elisabeth Bliss-Jaynes has my permission to photograph and or Videotape my child,

for the purposes of instruction, professional development, publication and or use on website. I understand that my child's privacy will be protected and used only for the above purposes.

Parent Signature _____

Date _____

Disclosure and Consent for Counseling Services

Elisabeth L. Bliss-Jaynes, MA, LPC, NCC, NBCT

Disclosure Statement

This Disclosure Statement offers general information about me and my counseling practice, and additional information required by Law. Please take a few minutes to read through this statement. If you have any questions, please feel free to talk with me about your questions prior to signing.

My Background

I earned a Master of Arts Degree in Counseling (School Counseling) along with certification in Special Education from Appalachian State University in 2005, a Bachelor of Science Degree in Industrial Arts and Vocational Education from Appalachian State University with teaching certification in 1983. I was trained to work with children, adolescents, and their families in the public school systems and during the last five years of private practice. I also have more than five years of experience providing traditional counseling, equine assisted experiential learning and equine assisted psychotherapy to people of all ages and abilities. I am EAGALA certified to offer the EAGALA modality of equine assisted learning and psychotherapy. I am currently a Licensed Professional Counselor in the state of North Carolina. I also practice school counseling in the public school system and have more than 15 years of experience as an educator with special needs children and adolescents.

Theoretical Orientation and Approach

I believe that you have the power within yourself to work through painful, confusing and chaotic situations and develop a plan to live a more satisfying and meaningful life. This can be achieved! In counseling, I will encourage you to use your freedom and creativity to discover how you would like your life to look. You will gradually learn how to uncover the true sources of your pain, and explore how you are coping with this pain. Together, we will develop a plan to help you move toward changing your life.

This includes (but is not limited to) developing insight, awareness and understanding of your struggles, and learning practical ways to manage the challenges you face in your life.

Confidentiality

As a therapist, I make your confidentiality my highest priority so that you will be able to do your work in an environment that is safe. There are a few guidelines, as well as professional ethics, that clarify how your health information will be protected by me, and when I can make disclosures to third parties. For example, North Carolina State law requires me to break confidentiality and inform the appropriate agency or person in the following situations: 1) if I believe that your life or someone else's life, safety or property is threatened or endangered; 2) if there is evidence or even suspicion of physical or sexual abuse or neglect of a minor child, dependent, developmentally disabled adult or elderly person; or 3) if a judge orders certain information disclosed in a legal proceeding. In legal proceedings when your psychological health is at issue (e.g., work related stress, divorce /custody battles, etc.) the attorney for the opposing side may have certain information subpoenaed. In that case, I would inform you of the subpoena. If you object to my complying with the subpoena, I may still be required to turn over the information, but only if ordered by a judge or otherwise required by law.

As part of good professional practice, there are times when I consult with colleagues on some therapeutic issues. When I do this it is with considerable caution and respect for your confidentiality. When and if I were to feel the need to consult with a colleague or expert regarding your therapy, I will do so only with your knowledge and written consent.

Course of Treatment

The course of treatment for effective counseling (including both frequency and duration) varies widely depending on a client's needs. If you are in crisis or are working on deeply embedded issues that are significantly impacting your life, we may want to meet on a weekly basis. If your needs are less urgent, meeting for sessions every two weeks may work well for you. Others prefer monthly or even quarterly "check-ups." The duration of treatment may range from a few sessions for addressing short-term goals, to several months or longer for deeper issues. During our first session, we will make an initial plan for the course of treatment.

Informed Consent and Feedback

In the interest of full disclosure, it should be noted that there are risks in any of the treatment methods I employ, including failure to relieve emotional distress. Of course, failure to receive treatment also leads to risks, including continued emotional distress. There are numerous other forms of mental health treatment based on different theories and techniques, as well as medical interventions that may also relieve emotional distress. I ask that you be an active participant in your treatment – including deciding when treatment is or is not effective.

I consider myself a consultant to you. As such, you are hiring me with a specific goal in mind. I always appreciate and am open to feedback regarding your needs and goals and evaluation of the therapeutic process. If you are dissatisfied with the direction of therapy or any particular session, please let me

know. You have a right to ask questions or request changes in the therapeutic process. At any point, you have the right to take a break from therapy, discontinue therapy, or request a referral to another therapist. If you do wish to take a break, discontinue therapy, or transfer to another therapist, please talk with me about it so that we can allow for appropriate closure or transition by talking about your experience, your progress, and your plans to solidify your progress outside of therapy.

If you believe that an act I have committed is unprofessional, I strongly encourage you to talk with me about your concerns. If, having done this, you feel your concerns are still unresolved, you have a right to notify the American Counseling Association (ACA)

Office Policies

Appointments and Cancellations: Appointments for standard fifty-minute counseling sessions can be made by telephone. Twenty-four hours notice is required if you need to cancel your appointment, so that I may offer that opening to another client. You may leave cancellation information on my voicemail or as a text. I will be happy to return your call to reschedule your appointment. Attempts to reach me during scheduled appointments will go to voicemail as I don't disrupt client sessions to answer the phone.

Emergencies: I check my confidential voicemail messages each working day. If you need to speak with me, please call and leave information about where I can reach you, and I will call you back at my earliest opportunity. If you feel your need is more urgent, please dial 911 for immediate help.

Counseling fees: Payment is due at the time of each session in the form of cash or check. At this time, I cannot accept credit or debit cards as methods of payment.



Agreement

Please sign below to indicate that you have read and understand all of the information in this disclosure, including the following: 1) all of the limits to confidentiality, 2) that in cases of family counseling, you give me permission to share any one individual's secrets with other individuals in the family if necessary, 3) that you read and understood the "Notice of Privacy Practices under HIPAA."

Client

Date

Release of Confidentiality

I _____ (self/parent if under 18 years) give Elisabeth Jaynes, LPC my permission to discuss _____ and any information needed with _____ (agency/name). I also give my permission for her to share information regarding _____ (name) with _____ (agency/name) in this process. I understand that I have the right to revoke this consent in writing at any time and that this consent is good for one year from this date unless I choose to revoke it.

Signature _____ (parent/Self)

Signature _____ (under 18)

Date _____

Insurance information:

Insurance Carrier: _____

Please attach a copy of insurance card or voucher. If your child receives mental health services from another therapist complete the following information.

Name of Therapist or group: _____

What type of service does your child receive? _____

Frequency of service _____ **how long has your child received this service?** _____

Please note this therapist on the release of confidentiality portion of this form(above) so that we can speak with them if needed.

PLEASE BE SURE TO SIGN THE ATTACHED CMS1500 FORM IN BLOCKS 12, AND 13 GIVING US PERMISSION TO FILE AND COLLECT INSURANCE PAYMENT. You will be responsible for any copayment at time of service.

Jakes Flat Farm and Stable

1454 Houston Mill Road, Conover, North Carolina (828) 256-2707

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____

Weight: _____

Address:

Any Illnesses Diagnosed:

Past/Prospective

Surgeries: _____

Medications:

Special Precautions/Needs:

Impairments in Dexterity, Flexibility, Movement:

Authorization for Emergency Medical Treatment

Name: _____

DOB: _____ Phone: _____

Address: _____

Physician's Name: _____

Medical Facility: _____

Health Insurance Co: _____

Policy # _____

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, I authorize Jakes Flat Farm and Stable to:

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

Consent Plan

This authorization includes x-ray, 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 unable to be reached.

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian

Signed in the presence of program personnel

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 emergency treatment/aid is required, I wish the following procedures to take place:

Consent Signature: _____

Client, Parent or Legal Guardian

Date: _____