Equine Therapy of NJ

Participant Application

Client's birth name:		
Client's preferred first name:		
Today's date:		
DOB:	**Age:**	☐ Minor or adult w/guardian ☐ Independent adult
Gender: ☐ M ☐ F ☐ Alternative (specify):		

Address:	
Phone number:	☐ Home ☐ Work ☐ Cell
Secondary phone number:	☐ Home ☐ Work ☐ Cell
Email address:	
Preferred contact method: ☐ Phone call ☐ Text message ☐ Email	

Demographic Information

Marital status: ☐ Married/Domestic partnership ☐ Widowed ☐ Divorced/separated ☐ Single ☐ Minor

Employment: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Student

Military status: ☐ Veteran ☐ Active duty ☐ N/A

Ability: ☐ I have a disability ☐ I do not have a disability

Brief description of disability:

The following is optional – for grant purposes only

Race/ethnicity:

☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Hispanic/Latino
☐ Native Hawaiian
☐ Pacific Islander
☐ White
☐ Other

Physician Information

Name of primary physician:
Contact number:
Name of psychiatrist:
Contact number:

Medical Insurance Information

Primary insurance:
Insurance ID #:
Group #:
Name of policy holder:
SS # of policy holder:
DOB of policy holder:

Emergency Contact Information

Name:
Relationship:
Phone #:
Email:

Consent to Treat

If emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while present on the Equine Therapy of NJ property, I authorize Equine Therapy of NJ to secure and retain medical treatment and transportation if needed and to release client records upon request to the authorized individual or agency involved in the medical emergency treatment. This authorization includes imaging (such as X-rays), surgery, hospitalization, medication and any treatment procedure deemed lifesaving by the treating physician. This provision will only be invoked if the person(s) above cannot be reached.

Please note that if you do not consent to medical treatment/aid in the event of an emergency, a parent or legal guardian **must remain on-site** at all times during equine-assisted activities.

☐ **I consent** to emergency medical treatment/aid as described above.

Preferred hospital/medical facility:

☐ **I do not consent** to emergency medical treatment/aid. A parent/guardian will be on-site at all times.

Please follow the non-consent plan described below.

Consent for Physician Contact

Equine Therapy of NJ may feel the need to contact your primary care physician for additional medical information as deemed necessary to provide safe, effective services. Indicate your level of consent below. Please note that if consent is not given, Equine Therapy of NJ reserves the right to discontinue services if the client's safety is a concern.

☐ **I consent** to Equine Therapy of NJ contacting my primary care physician if additional medical information is needed to provide services.

☐ **I do not consent t**o Equine Therapy of NJ contacting my primary care physician if additional medical information is needed to provide services.

Client name (print):

Client signature:

Parent/legal guardian (for minors, adults w/guardian):

Today's date:

Session Format & Payment

1. Therapy sessions are 50 minutes in length, with 10 minutes in between to promote client confidentiality. Please do not arrive early for your session.

2. Sessions are confirmed 24 hours in advance via text message to the phone number you have provided. To avoid a cancellation fee, please call within 24 hours prior to your scheduled session to cancel or reschedule within the same week.

3. If sessions are canceled due to inclement weather, Equine Therapy of NJ will notify you via text message to the phone number you have provided.

4. Payment will be handled through the Equine Therapy of NJ business office. If you are not utilizing insurance, the fee per session is $125.

Discrimination Disclosure

It is the policy of Equine Therapy of NJ to provide equal opportunity for all persons and prohibit unlawful discrimination for any reason, including but not limited to age, disability, race, creed, religion, gender, national origin and veteran status. This policy applies to all current and potential clients as well as to staff and volunteers.

Client name (print):

Client signature:

Parent/guardian signature (for minors, adults w/guardians):