Application for Art Therapy

APPLICANT INFORMATION

Applicant Name: _____ Date: _____

Parent or Legal Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone #: (H): _____ (C): _____ (W): _____

Height: _____ Weight: _____ Date of Birth: _____

Email: _____

Gender (check one): [ ] Male [ ] Female

Sexual identity and preferred pronouns: _____

Ethnicity: _____

Spiritual identity: _____

Intake information

Please answer each question to the best of your ability. Please write NA if a question does not apply so that we know you reviewed the question.

When did you/your child first start experiencing problem(s) for which you are seeking art therapy?

_____

_____

_____

_____

How often does the problem occur?

_____

_____

Do you/your child have thoughts of harming themselves? ☐ YES ☐ NO

Have you/your child ever attempted to harm themselves? ☐ YES ☐ NO

If yes, please explain:

_____

_____

_____

Do you/your child have any thoughts of harming someone else? ☐ YES ☐ NO

Application for Art Therapy

Have you/your child ever attempted to harm someone else? ☐ YES ☐ NO

If yes, please explain:

_____

_____

Have you/your child ever had previous therapy/counseling of any kind? ☐ YES ☐ NO

If yes, when and for how long? _____

_____

Was this experience helpful? ☐ YES ☐ NO

Have you/your child been hospitalized for emotional/behavioral problems? ☐ YES ☐ NO

If yes, when/where was this: _____

_____

Have you/your child taken medications to treat emotional/behavioral problems? ☐ YES ☐ NO

If not listed previously, please include here: _____

_____

_____

To your knowledge, were you/your child ever physically, verbally, or sexually abused? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

Have you/your child experienced any other trauma or traumatic events? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

Have you/your child experienced any parental separations, divorces, or deaths? ☐ YES ☐ NO

If yes, when? _____

How old were you/your child at the time? _____

Please describe the circumstances: _____

_____

_____

Application for Art Therapy

If parents are separated or divorced, who has custody of your child?_____

How often does the other parent see this child?_____

Please list age and sex of each sibling (including step-siblings and those deceased):_____

_____

_____

Other than children already indicated above and parents, who else lives in this child's household?

_____

Describe any difficulties or problems you/your child is having at home:_____

_____

_____

What kinds of stressful event have family members experienced recently?_____

_____

Has anyone in your/your child's family had treatment for emotional problems? ☐ YES ☐ NO
If yes, please briefly explain(who/when):_____

_____

Has anyone in your family ever attempted or committed suicide? ☐ YES ☐ NO
If yes, please briefly explain(who/when):_____

_____

What grade or level of education is your child currently at?_____

Favorite subjects:_____

Least favorite subjects:_____

Describe any difficulties or problems you/your child is having in school:_____

_____

Describe any complications that occurred during pregnancy:_____

_____

Are you/your child adopted? ☐ YES ☐ NO
If yes, please provide adoption history:_____

_____

When were developmental milestones met? _____
As a young child, did you/your child have problems getting along with others? ☐ YES ☐ NO
If yes, describe:_____

_____

Application for Art Therapy

To your knowledge, have you/your child experimented with alcohol/drugs? ☐ YES ☐ NO

Are you concerned that you/your child might be developing a problem with alcohol/drugs? ☐ YES ☐ NO

If yes, please explain:_____

_____

Do you/your child have pending legal problems? ☐ YES ☐ NO

If yes, please explain:_____

_____

Please describe your/your child's strengths and positive characteristics:_____

_____

_____

_____

Other information you feel is important that was not asked about:_____

_____

_____

_____

_____

_____

_____

_____

_____

Application for Art Therapy

MEDICAL HISTORY/PHYSICIAN RELEASE

Phone: 757-566-1775 Fax: 757-566-1772

(Physician must complete and sign Pages 5 and 6)

Applicant Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Height: _____ **Weight:** _____ **Date of Birth:** _____

Primary Diagnosis: _____ **ICD10 Code:** _____

Onset (please check one): ☐ **Birth** ☐ **Childhood** ☐ **Adolescence** ☐**Adult**

Secondary: _____ **ICD 10Code:** _____

Tertiary: _____ **ICD 10Code:** _____

*****Please answer the following questions for participants with Down Syndrome*****

Atlantodens Interval X-Ray Results: ☐ POSITIVE ☐ NEGATIVE X-Ray Date: _____

Neurological Symptoms of Atlantoaxial Instability? ☐ YES ☐ NO

Please provide a copy of negative X-Ray Results when returning application to Dream Catchers

PLEASE LIST ALL CURRENT MEDICATIONS (Additional medications can be listed on separate paper)

1. _____ Taken For _____
2. _____ Taken For _____
3. _____ Taken For _____

Ambulatory: ☐ YES ☐ NO Uses: ☐ Crutches ☐ Braces ☐ Cane ☐ Walker ☐ Wheelchair

Special precautions needed with this applicant: _____

Please answer the following medical questions:

Question	Answer
Does the applicant have seizures?	☐ YES ☐ NO
• Are seizures controlled?	☐ YES ☐ NO
• Type of Seizure	
• Date of Last Seizure	
Does the applicant have any indwelling medical devices?	☐ YES ☐ NO
• Please list devices if applicable	

Application for Art Therapy

Please CHECK if the following APPLIES to participant:_____

Print Applicant's Name

BOTH applicant/parent/legal guardian (P/G) AND PHYSICIAN (DR) *must complete the following*:

Please indicate if any of the conditions below are present and to what degree.

P/G	*DR*	*System Area*		*P/G*	*DR*	*System Area*
		Allergies (incl. asthma)				**Spinal Joint Fusion/Fixation**
		Hearing Impaired / Sensitivity				**Spinal Joint Instability/Abnormalities**
		Balance				**Hydrocephalus/Shunt/Shunt revision**
		Cardiac				**Paralysis Due to Spinal Cord Injury**
		Circulatory / Blood Pressure Control				**Spinal Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia**
		Cognitive Impairment				**Stroke**
		Emotional/psychological				**Indwelling catheters/medical equipment**
		Immunity				**Medication side effects**
		Skin Break Down				**Allergies**
		Learning Disability				**Animal Abuse**
		Muscular				**Cancer**
		Neurological Condition				**Physical/Sexual/Emotional Abuse History**
		Orthopedic Condition				**Dangerous to Self or Others**
		Pulmonary				**Fire setting**
		Speech Impairment				**Hemophilia**
		Tactile Sensation Impairment				**Medical Instability**
		Visual Impairment				**Migraines**
		Atlantoaxial Instability-include neurologic symptoms				**Peripheral Vascular Disease**
		Coxa Arthrosis				**Compromised Respiratory**
		Cranial Deficits				**Recent Surgeries- List**
		Heterotopic Ossifications/Myositis Ossificans				**Substance Abuse**
		Internal Spinal Stabilization Device				**Thought Control Disorders**
		Joint subluxation/dislocation				**Weight Control Disorders**
		Pathological Fractures				**Body Temperature Deregulation**
						Allergy to Bee Stings

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. I understand that Dream Catchers will weigh this medical information against the existing precautions and contraindications. Therefore, I refer this person to Dream Catchers for ongoing evaluation to determine eligibility for participation.

Physician's Printed Name:_____

Title: MD / DO / NP / PA / Other:_____ License/UPIN#:_____

Physician's Signature:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Office Phone #:_____ Office Fax #:_____

Application for Art Therapy

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____(APPLICANT NAME), hereby authorize and request that _____(PROVIDER NAME) may release to Dream Catchers at the Cori Sikich Therapeutic Riding Center the following information (please check the allowable information):

Check Box	Description	Check Box	Description
	Admission for Treatment		Diagnosis
	Psychiatric Evaluation		Psychological Testing Results
	Treatment Progress Notes		Discharge Summary
	Physician Orders		Other:

The purpose of this disclosure is for the development of an Equine Integrated Art Therapy Plan and program. I understand that this authorization will remain in effect for 1 year. This information will not be forwarded to any other provider or agent. This information will be released in the following format (Check All That Apply):

Check Box	Method of Release
	Verbal per telephone
	Electronic
	Snail Mail
	Hand Carried

_____ _____

Applicant Signature (if 18 or older), Parent or Legal Guardian Date

CONFIDENTIALITY POLICY

Maintaining the confidentiality of our participants' medical and sensitive information is of utmost importance to the staff at Dream Catchers. Participants and their families have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. Dream Catchers staff and volunteers will preserve this right of confidentiality for all individuals in its program. DC staff, volunteers, and workshop participants will keep confidential all medical, social, referral, personal, and financial information regarding a person and his/her family. All participants, their families, volunteers, employees, and guests have a right to confidentiality. Equine Facilitated Psychotherapy and Speech services are medical services and federal confidentiality regulations apply for participants in these services. Anyone who works, volunteers for, participates in, or provides services to Dream Catchers is bound by this policy. This includes, but is not limited to, full and part time staff, independent contractors, temporary employees, volunteers, and board members. In effect, this policy applies to anyone connected to Dream Catchers who could obtain medical/sensitive information accidentally or purposely. Confidentiality includes photographic/video imaging. I affirm that I understand this policy in its entirety and I agree to comply.

Signature: _____ Date:_____

Applicant (if 18 or older), Parent or Legal Guardian

Application for Art Therapy

Documentation of Client's Informed Consent for Evaluation/Treatment

Art Therapy is a mental health service offered to you/your child for short-term support. Art Therapy may also support positive character development through psychoeducational art based experiences. The art therapist and you/your child will develop goals for working in art therapy. Psychotherapy involves a commitment to work toward change and to be actively involved in treatment. This may trigger the emergence of strong feelings and thoughts. Emotional and physical safety is ongoing treatment goals that will continually be assessed during Equine Assisted Psychotherapy. While verbal expression of intense feelings are appropriate in counseling, acting out feelings in a violent or destructive manner is not and may result in termination of treatment or referral to a more appropriate therapeutic setting.

Because equine assisted psychotherapy is conducted in an open setting (in a barn, pasture or arena); maintaining confidentiality poses certain challenges. At times, there may be other staff or clients at the facility during your session, which may compromise your privacy. We will make every effort to protect your privacy and there will always be a designated space for privacy when requested. However, there may be occasions, which are mandated by law as described in the HIPAA Notice of Privacy Practice where we will be required to disclose personal information.

Therapy involves a large commitment of time, money, and energy. You are entitled to and will receive non-coercive service that protects your right to self-determination. You will be responsible for the payment of service at the time of each appointment. If an appointment is missed and not canceled or rescheduled 24 hours prior to the appointment time, you will be responsible for payment. If Dream Catchers is not affiliated with your insurance network, we will be happy to provide you with whatever paper work is necessary to facilitate reimbursement from your insurance company. Please contact them as soon as we have met to obtain authorization and determine whether they require a treatment plan, copy of paid invoice, etc.

By signing below, I agree to begin treatment and accept responsibility for payment for services provided. I have read about the potential limits of confidentiality as described on the sheet entitled NOTICE OF PRIVACY PRACTICES. I have also read and understand the policies described on the CLIENT'S INFORMED CONSENT FORM. I accept these conditions for participating in treatment and I understand that I can discuss any concerns with my therapist at any time. Dream Catchers looks forward to working with you and we will make every effort to provide quality service. We welcome your questions, suggestions and inquiries.

Your signature below indicates; 1) that you have read the information in this document; 2) that I have ensured your understanding of the contents; 3) that you give consent voluntarily; and 4) that you agree to abide by it terms during our professional relationship.

Printed Name:_____ Date:_____

Signature (Applicant/Guardian if under 18 years of age):_____

Application for Art Therapy

CONSENT FOR REPRODUCTION AND PUBLICATION OF MEDIA/ VIDEOGRAPHY / IMAGES

Any information about you, your child, and your/your child's artwork is held with utmost confidentiality and can only be released by either your written signed consent or by court order.

☐ **I DO CONSENT** ☐ **I DO NOT CONSENT**

to authorize the use and reproduction by Dream Catchers at the Cori Sikich Therapeutic Riding Center of any and all photographic, any other audio/visual materials taken of me and/or my child or the participant for whom I am the legal guardian of, and any artwork produced by me and/or my child or the participant for whom I am the legal guardian of or other family members for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Applicant (if 18 or older), Parent or Legal Guardian

CONSENT FOR REPRODUCTION AND PUBLICATION OF ARTWORK

☐ **I DO** ☐ **I DO NOT** (Please check one)

agree to allow Dream Catchers at the Cori Sikich Therapeutic Riding Center to use and/or display and/or photograph, and to reproduce my/my child's artwork for educational purposes, consultation with other mental health professionals, presentation at professional conferences, or publication in a professional journal.

Signature: _____ Date: _____

Applicant (if 18 or older), Parent or Legal Guardian

Application for Art Therapy

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name:_____ DOB:_____

Address:_____

City/State/Zip:_____

Phone #'s: (H):_____ (C):_____ (W):_____

In the event of an emergency, contact:

Name:_____ Phone:_____

Relationship:_____

Physician's Name:_____ Physician Phone:_____

Medical Facility:_____ Facility Phone:_____

Heath Insurance Company:_____ Policy #:_____

In an effort to provide the best care possible please indicate below:

I am allergic to the following medications:_____

I have the following ongoing medical conditions (diabetes, seizures, etc):_____

_____ _____

Applicant/Volunteer/Guest/Staff Signature (Parent / Guardian if under 18) Date

CHECK ONE OF THE OPTIONS BELOW TO INDICATE CONSENT OR NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

CONSENT FOR EMERGENCY MEDICAL TREATMENT

□ **I DO** consent for emergency medical treatment in the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with Dream Catchers.

I authorize Dream Catchers and/or its representatives to:

1. Obtain medical treatment and/or transportation if needed:
2. Release records upon request to the authorized agency or its representative involved in the medial emergency treatment.

NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

□ **I DO NOT** give my consent for emergency medical treatment in the case of illness or injury while on the premises of or in connection with Dream Catchers. In the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with Dream Catchers I wish the following procedure to take place (***LIST PROCEDURE ON LINE BELOW):***

_____

Note: Dream Catchers is unable to guarantee that emergency medical treatment will be withheld

Application for Art Therapy

Release, Waiver & Indemnity Agreement

I, the undersigned or parent or legal guardian of the undersigned (either as a "Participant, Volunteer, or Staff"), desiring to utilize the premises known as the Cori Sikich Therapeutic Riding Center and the adjoining properties known as 10128 Fire Tower Road and 10102 Fire Tower Road, and any adjoining property owned by Daniel Potter, Karen K. Potter, Neal E. Knemeyer, or NDK Investments, LLC, and Jennifer and Joshua Thibeault, and their heirs, for their properties located at 10046,10058,10070 Fire Tower Road, Toano, VA 23168 collectively known as "the Premises")and the facilities either owned or controlled by Dream Catchers at the Cori Sikich Therapeutic Riding Center ("DCTR"), and to participate in programs offered by DCTR (the Programs), do herby affirm that as a Participant, Volunteer, or Staff is voluntarily entering upon the Premises to participate in the Programs, and I, as the undersigned or parent or legal guardian of the undersigned, do herby willingly enter into this Release, Waiver and Indemnity Agreement.

I recognize that, under Virginia law, an equine activity sponsor or professional is not liable for an injury to or the death of a Participant, Volunteer, or Staff in equine activities resulting exclusively from the inherent risks of equine activities. I fully understand that the activity of mounting, riding, boarding, feeding, or even being near a horse, involves numerous dangers and risks of injury to the Participant, Volunteer, or Staff and I completely release the owner of the Premises, and DCTR and its officers, directors, volunteers, employees, or its agents from any and all liability for any and all injuries from the Participant's, Volunteer's, or Staff's engagement in the Programs offered by DCTR.

I expressly agree that this Release, Waiver, and Indemnity Agreement shall be governed and construed as being sufficient to satisfy the assumption of risk and waiver requirements necessary to relieve equine activity sponsors and equine professionals from liability under the Virginia Equine Activity Liability Act, Section 3.1-796.130, *et.seq*. of the Code of Virginia (the "Act"), and the owners of the Premises, DCTR and its officers, directors, volunteers, employees, and agents are covered as equine activity sponsors and/or equine professionals by the provisions of the Act. This Release, Waiver, and Indemnity Agreement shall be governed and construed by the laws of the Commonwealth of Virginia, regardless of where any injury or loss shall occur. In the event that any portion of this Release, Waiver, and Indemnity Agreement shall be declared unenforceable, such declaration shall not affect the remaining terms of this document, which shall survive intact.

I am also aware and consent to Participant's, Volunteer's, or Staff's inclusion in a study performed by DCTR that, in the interest of improving the quality and effectiveness of the programs offered, will gather data on the program participants. Such data will include, but not limited to, the age, gender, dates of participation, and level of satisfactions of the program participants. Program participants may be selected for the study at random, and DCTR affirms that all program participants not selected for the study will be treated in a manner substantially identical to those program participants. Data will be held strictly confidential and not published in any way or as part of any publication.

I hereby give my permission to participate in the Programs offered by DCTR as a Participant, Volunteer, or Staff, and in consideration, agree individually and as applicable, on behalf of my child or ward, to the terms of the above agreement and release of liability.

_____ _____

Printed Name of Applicant, Volunteer, or Staff Member Date

_____

Signature of Applicant, Volunteer, or Staff Member

_____

Signature of Parent or Guardian of Applicant, Staff or Volunteer if under the age of 18

Application for Art Therapy

COVID-19 Assumption of Risk and Waiver of Liability

Coronavirus/COVID-19 Warning and Disclaimer

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person during close contact. Participating in or observing activities at Dream Catchers at the Cori Sikich Therapeutic Riding Center (the "Center") could increase your risk of contracting COVID-19, and **Dream Catchers cannot guarantee that you will not become infected with COVID-19.**

Acknowledgment of Risk

I, the undersigned, for myself and, if applicable, as parent/guardian on behalf of the minor named below, hereby acknowledge and agree that in consideration for the undersigned participating in or observing activities at the Center: (1) the undersigned is assuming the risks related to COVID-19 inherent to gathering with others and using common facilities and hereby waives the undersigned's rights to claim liability of Dream Catchers or others resulting from the assumption of such risks; and (2) Dream Catchers is not responsible for sickness or for loss of any kind as a result of COVID-19. I further understand that certain activities at the Center will require additional safety precautions and equipment due to COVID-19, and that, due to physical safety concerns and sudden emergent conditions, certain activities may not permit social distancing of 6 feet per person at all times.

Dream Catchers has taken certain steps to implement recommended guidance and protocols issued by the Centers for Disease Control and Prevention and the Virginia Department of Health for slowing the transmission of COVID-19. The undersigned acknowledges receipt of Dream Catchers' current policies and requirements for participation in or observation of activities at the Center in response to such guidance and protocols ("Dream Catchers' COVID-19 policies and requirements"). The undersigned acknowledges and agrees that Dream Catchers may revise its policies and requirements at any time based on updated recommended guidance and protocols issues by the public health agencies. **The undersigned agrees to comply at all times with Dream Catchers' COVID-19 policies and requirements.**

By signing this agreement, **I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 while at the Center and that such exposure or infection may result in personal injury, illness, permanent disability, and/or death**. I understand that the risk of becoming exposed or infected by COVID-19 at the Center may result from the actions, omissions, or negligence of myself or of others, including Dream Catchers. I hereby forever release, waive, discharge, and hold harmless, and agree not to sue or assert any claim against, Dream Catchers (including its directors, staff, employees, volunteers, and agents) for any loss or damages arising from such exposure or infection. I understand that by signing this document, all liability of Dream Catchers (including its directors, staff, employees, volunteers, and agents) to myself for any such loss or damages will be forever extinguished. I, the undersigned, have read, understand and accept the terms of this Assumption of Risk and Waiver of Liability form. I further acknowledge that no oral representations have been made to me as an inducement to sign this form.

_____ _____

Printed Name of Participant, Volunteer, Guest, or Staff Date

_____

Signature of Participant, Volunteer, Guest, or Staff

_____

Signature of Parent or Guardian of Participant, Staff, Guest, or Volunteer if under the age of 18

Application for Art Therapy

NOTICE OF PRIVACY PRACTICES

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The **Health Insurance Portability and Accountability Act of 1996 "HIPAA"** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your protected health information and how we may use and disclose your health information.

We may use and disclose your protected health information (PHI) only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: if we have reason to believe that a child has been subjected to abuse or neglect, we must report this belief to the appropriate authorities.
- Adult and Domestic Abuse: we may disclose protected health information regarding you if we reasonably believe that you are a victim of abuse, neglect, self-neglect or exploitation.
- Health Oversight Activities: if we receive a subpoena from the Virginia Board of Social Work Examiners because they are investigating our practice, we must disclose any PHI requested by the Board.
- Judicial and Administrative Proceedings: if you are involved in a court proceedings and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. You will be informed in advance if this is the case.
- IF you are under 18 years of age, Virginia law allows your parents or guardians to request information and/or records related to our treatment.
- Serious Threat to Health and Safety. If you communicate to us specific threat of imminent harm against another individual or if we believe that there is a clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm.

Application for Art Therapy

NOTICE OF PRIVACY PRACTICES CONTINUED

- If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to Dream Catchers, P.O. Box 1261, Williamsburg, VA 23187.

- The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protective health information. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request we will discuss with you the details of the request and denial process for PHI
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.

If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact Dream Catchers at (757) 566-1775.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above provides you with the appropriate address upon request.

I acknowledge the receipt of this Notice of Privacy Practices.

Printed Name:_____ Date:_____

Signature (Parent/Guardian if under 18 years of age):_____

Application for Art Therapy

HIPAA Release of Information Consent

_____

Name of Client

_____

Parent or Legal Guardian (if client is under the age of 18)

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for Dream Catchers to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give Dream Catchers permission to:

Check Box as appropriate

□ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

□ Disclose my complete health record except for the following information

- □ Mental health records
- □ Communicable diseases including, but not limited to, HIV and AIDS
- □ Alcohol/drug abuse treatment records
- □ Genetic information
- □ Other (Specify)

  _____
  _____
  _____
  _____

Form of Disclosure:

- □ Electronic copy or access via a web-based portal
- □ Hard copy
- □ Over the phone

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

Application for Art Therapy

HIPAA Release of Information Consent Continued

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

Phone Number:_____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Check Box as appropriate

- ☐ From _____ to _____ Or
- ☐ All past, present, and future periods Or
- ☐ The date of the signature in section VI until the following event:

  _____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Dream Catchers
Attn: Operations Manager
PO BOX 1261, Williamsburg, VA 23187

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Application for Art Therapy

HIPAA Release of Information Consent Continued

Section VI – Signature

_____

Printed Name of Client/Parent or Legal Guardian

_____

Signature of Client/Parent or Legal Guardian

_____

Date

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form:_____

Date:_____

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____

Application for Art Therapy

Financial Policies

(Please retain this page for your records)

- Dream Catchers does not bill insurance companies for Art Therapy services. We will provide you with the information so that you may bill and seek reimbursement from your insurance company. You will be responsible for all charges in full, including those not covered by your insurance company. Payment is due at the time of service in the form of cash, check, or charge.

- **We require a 24 hour cancellation notice or a $50.00 missed appointment fee will apply**.

- Payment for Art Therapy services are due in full at the time of service. The cost per appointment is $85.00. Scholarships for services **may** be available and are based on financial need. A separate scholarship application will be required.

- There is a $50 returned check fee for any check returned by our bank for insufficient funds.

- Please print all Dream Catchers documents emailed to you for your records and reference. They are your "official" notices.

- Clients/Parents/guardians must call the cancellation hotline to let staff know if they are running late or contact your therapist if they have requested to be contacted directly.

- Please call the **CANCELLATION HOTLINE at 757-810-8826** as early as possible when you or your participant are running late or unable to attend a session. (Please notify the programs office about any planned abscesses). Please DO NOT CALL 757-566-1775 about late or missed lessons!

I have read and understand the financial policies.

_____ _____

Signature Date

Application for Art Therapy

Art Therapy Payment & Registration Agreement

Applicant Name:_____

Parent/Guardian Name(s):_____

Address:_____

City/State/Zip:_____

Home #:_____ Cell #:_____ Work #:_____

Email #1:_____ Email #2:_____

Cost

$85.00 per appointment

Please make a payment selection:
I/We choose to pay in the following way:

☐ By check (Please place in the grey metal lock box in the barn aisle or drop off at the Office Building)

☐ By bank auto draft (Please ask for an auto draft form if you are selecting this option)

☐ By Credit Card (Please complete the information below)

☐ VISA ☐ MC ☐ AMEX ☐ DISCOVER Card Number:_____

Name on Card: _____

Expiration:_____ **Security Code:**_____ **Billing Zip Code:**_____

I/we hereby authorize Dream Catchers to charge the payments that correspond with the payment plan selected for each session for which the participant is enrolled. This agreement is valid ONLY for the services indicated above. Fees are due at the time of service.

Authorized Signature: _____ Date: _____