The Equine Healing Collaborative
Individual Psychotherapy Intake Packet

Hello and welcome to The Equine Healing Collaborative! We are happy to have you join us and hope your time here can assist you in building new experiences that will help you as you move forward with any challenges you may be facing. We at the Equine Healing Collaborative will be spending time with you and hope you will find, as we have, the healing power of Mindful Equine Assisted Psychotherapy. Regardless of your level of comfort or experience with horses we have found that horses can be helpful in almost any situation.

Your first session with us will encompass an assessment, treatment plan, and safety plan (if needed) that you will build with your primary therapist. Once that is complete, we will begin the process of engaging in Mindful Equine Assisted Psychotherapy. When we end our time together your therapist will provide you with referrals for continued services if needed.

Our services are based on a sliding scale, scholarship, or Medi-Cal/Beacon, and our funds are used to assist us with taking care of our horses. They help us help you, and in return love to eat treats, get veterinary care, and other supplies.

We also have forms for you to sign and will provide you with The Equine Healing Collaborative Notice of Privacy Practices. The forms we will need include:

- Consent for treatment
- Signature that you received notice of privacy practices
- Unlicensed clinician agreement (if needed)
- Release of liability (if needed)

You will be asked to sign copies and bring them to your first appointment. Fill them out to the best of your abilities and we will guide you if needed. If you have any questions or concerns regarding these forms, please contact:

Jennifer Fenton LMFT @ 831-582-1017.

Sincerely,
The Equine Healing Collaborative Staff

Client Name:_____

Clinician Name:_____

Informed Consent for Equine Assisted Psychotherapy

Welcome to The Equine Healing Collaborative! We hope you will find healing in your work with us and your equine partner. There is no riding in our program and all work takes place on the ground. This document contains important information about our services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

EQUINE ASSISTED PSYCHOTHERAPY (EAP)

EAP is a relationship between individuals and equines that works in part because of clearly defined rights and responsibilities held by each person. As a client in EAP, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Equine Assisted Psychotherapy comes with certain risks. Although every effort has been made to ensure that our equines are safe around individuals, they are large animals of prey and if they feel threatened or trapped will attempt to escape that threat (escape can include, pulling, running, kicking, jumping, or biting). It is imperative that you wear appropriate clothing (jeans and closed toed sturdy shoes) to every session. If at any time, you feel your safety is threatened by your equine partner, please let us know. Two basic areas to avoid are standing directly in front of or behind your equine partner. Our clinicians will remind you of these safety rules if needed.

The Equine Healing Collaborative relies on the generous allowance of space by 2 public boarding facilities, Flying Pig Ranch and Deerhorn Ranch, in addition to the EHC main location at Bella Tierra Ranch. There are members of the public on the properties at various times throughout the day. Clinicians will make every effort to guard your session by ensuring that your therapy session takes place away from the milieu of the barn, however, barn members have free access to all parts of the property. In the event that another barn member approaches your session, we will suspend the session temporarily and resume once we feel your confidentiality can be secured.

EAP has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of EAP can require discussing the unpleasant aspects of your life. However, EAP has been shown to have benefits for individuals who undertake it. EAP often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. EAP requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

EAP is a strength based type of therapy. The first session will involve an evaluation of your needs, followed by a treatment plan where we will agree to the goal of EAP. You should evaluate this information and make your own assessment about whether you feel comfortable working with The Equine Healing

Collaborative. If you have questions about our procedures, please discuss them whenever they arise. The Equine Healing Collaborative will provide you with at least three referrals if you wish to continue psychotherapy upon termination with us and we encourage you to continue your journey to healing.

APPOINTMENTS

Appointments will ordinarily be 40-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours notice. If you do not contact us within the 24 hours, you will be charged a 50.00 no show fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. In addition to on site therapy services, we also offer telehealth services in the event of inclement weather if needed, illness or other circumstances. We take your treatment seriously and weekly appointments are necessary in order to assist you in achieving your treatment goals. If you are unable to attend your weekly appointments and you miss more than three sessions in three months, we will need to re-evaluate your current treatment regimen including termination or placement on our waitlist if you are unable to attend regularly.

EHC FEES

The Equine Healing Collaborative is a not-for-profit organization and we offer our services for a sliding scale fee (see sliding scale fee chart), Medi-Cal/Beacon, Scholarship, Victims of Crime, you will not be turned away based on your ability to pay, however, you may be placed on a waitlist. Please discuss your ability to pay with your clinician. The total amount of treatment will depend on the number of sessions needed, the number of sessions needed is unknown at the onset of treatment and will be based on your needs, preferences, and progress made in treatment. Signing of this document includes an understanding that we have provided you with a "good faith estimate" of costs to you. Your clinician will discuss costs to you, enter all payments collected in our electronic health record, and keep open lines of communication with you regarding payment.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the psychological services that we provide. Your records are maintained via an electronic health record. We keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your donation records. You may have access to your records at any time; in the event you would like to obtain these records, please contact Jennifer Fenton LMFT, in writing at theequinehealingcollaborative@gmail.com

CONFIDENTIALITY

Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

RECORDING SESSIONS

The State of California does not allow the recording of confidential interactions with the consent of both parties present. Se Ca. Penal Code 632 This law applies where an individual has an objectively reasonable

expectation of confidentiality. EHC staff may ask to record all or part of a therapy session for educational purposes and will maintain an air of transparency when recording. All agreements to record sessions will be documented in our electronic health record.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. For the treatment of children , we request an agreement between the client and the parents allowing us to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy if requested by either party. All other communication will require the child's agreement, unless we feel there is a safety concern, in which case we will make every effort to notify the child of our intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING US

We are often not immediately available by telephone. We do not answer the phone when we are with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from us or we are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact the crisis team with Monterey County Behavioral Health 888-258-6029 (follow prompts to speak to crisis team member), 2) go to your local hospital emergency room, or 3) call 911 and ask to speak with a CIT trained officer (these are police officers trained to deal with mental health emergencies). We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering our practice.

OTHER RIGHTS

If you are unhappy with what is happening in EAP, we hope you will talk with us so that we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____ _____

Signature of Client or Guardian Signature of Client (under the age of 18)

_____(_____) _____

Printed Name of Client or Guardian (relationship) Printed Name of Client (under the age of 18)

Date _____

The Equine Healing Collaborative Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website. By signing below you acknowledge you have read and understand the Terms of this Notice.

Printed Name_____(Relationship)_____

Signature_____ (Effective Date)_____

The Equine Healing Collaborative Authorization for Use/Exchange, and or Disclosure of Confidential Behavioral Health Information

Completion of this document authorizes the use of release of confidential behavioral health information about your or your child. It is important that you complete this Authorization if you wish to authorize The Equine Healing Collaborative to use, disclose, or exchange confidential health information about you or your child.

I, _____(name or representative) hereby authorize The Equine Healing Collaborative to disclose confidential information about me/my child to the following person/entity.

_____(name of person or entity), for the following purpose(s):

_____
_____
_____

This authorization expires 90 days after my or my child's treatment ends or when there is no longer any need for access by The Equine Healing Collaborative treatment providers, whichever is sooner.

I may refuse to sign this authorization. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke authorization at any time either in writing or by verbally informing my Equine Healing Collaborative Clinician. My revocation will take effect upon receipt, except to the extent others have acted in reliance on this Authorization.

I have a right to receive a copy of this authorization.

Information used, exchanged, and disclosed pursuant to this authorization will not be redisclosed by any user or recipient except as required or permitted by law.

EHC Clinician_____ (Date)_____

Client Printed Name_____

Client Signature_____ (Date)_____

Guardian Printed Name_____

Guardian Signature_____ (Date)_____

The Equine Healing Collaborative Release of Liability

In exchange for participation in the activity of Mindful Equine Assisted Psychotherapy organized by The Equine Healing Collaborative LLC and/or use of the property Vista Nadura (8767 Carmel Valley Road, Carmel, CA 93923), Flying Pig Ranch (10101 Equestrian Place, Salinas, CA 93907) and Divine Equine Therapy, all animals and staff of The Equine Healing Collaborative, services of The Equine Healing Collaborative LLC, I agree for myself and if applicable, for the members of my family to the following:

Agreement to follow directions. I agree to observe and obey all posted rules and warnings, and further agree to follow any oral instructions or directions given by The Equine Healing Collaborative staff, agents, and/or volunteers.

Assumption of the risks and release. I recognize that there are inherent risks associated with the above described activity and I assume full responsibility for personal injury to myself and (if applicable) my family members, and further release and discharge The Equine Healing Collaborative LLC, Vista Nadura, Divine Equine Therapy, Flying Pig Ranch and its owners and operators, loss or damage arising out of my or my family's use or presence upon the facilities used by The Equine Healing Collaborative LLC, whether caused by fault of myself, my family, the Equine Healing Collaborative LLC or any of The Equine Healing Collaborative's horses.

Indemnification. I agree to indemnify and defend The Equine Healing Collaborative LLC, Vista Nadura, Flying Pig Ranch and Divine Equine Therapy against all claims, causes of action, damages, judgments, costs or expenses, including attorney fees and other litigation costs, which many in any way arise from my or my family's use of or presence upon the facilities of The Equine Healing Collaborative LLC, Vista Nadura, Divine Equine Therapy.

Fees. I agree to pay for all damages to the facilities of The Equine Healing Collaborative LLC, Vista Nadura, Divine Equine Therapy, Flying Pig Ranch property caused by any negligent, reckless, or willful actions by me or my family.

Consent. I, _____ (name), _____(child's name), consent to the participation of myself and/or child in the activity of Mindful Equine Assisted Psychotherapy and/or Course on Empathy, and agree, on behalf of the minor to all of the terms and condition of this agreement. By signing this Release of Liability, I represent that I have legal authority over and custody of _____(child's name).

Medical Authorization. In the event of an injury to participant and/or above minor during the above described activities, I give my permission to The Equine Healing Collaborative LLC, or employees, volunteers, or other representative to arrange for all necessary medical treatment for which I will be financially responsible. This temporary authority will begin on _____(today's date) and will remain in effect during the duration of my presence in The Equine Healing Collaborative's program. The Equine Healing Collaborative LLC shall have the following powers:

a. The power to seek appropriate medical treatment or attention on behalf of me or my child as may be required by the circumstances, including without limitation, that of a licensed medical physician and/or a hospital;

b. The power to authorize medical treatment or medical procedures in an emergency situation; and

c. The power to make appropriate decisions regarding clothing, bodily nourishment and shelter.

Applicable Law. Any legal or equitable claim that may arise from participation in the above shall be resolved under California Law.

No Duress. I agree and acknowledge that I am under no pressure or duress to sign this agreement and that I have been given a reasonable opportunity to review it before signing. I further agree and acknowledge that I am free to have my own legal counsel review this agreement if I should so desire.

Arbitration. Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Printed Name_____ (Relationship)_____

Signature_____ (Date)_____

Emergency Contact _____ (Phone Number)_____

Unlicensed Clinician Waver

The Equine Healing Collaborative utilizes unlicensed clinicians that are in the process of completing their requirements for licensure and other staff that are not licensed eligible. These clinicians have been given the authorization by the Department of Mental Health of the State of California to provide mental health services. All unlicensed clinicians work under the supervision of a licensed mental health professional. Listed below is the name of the unlicensed clinician that will be providing services to you, child (or guardian) and/or your family. The name of the licensed mental health professional that will be providing supervision to your clinician is also listed below. Please call the supervising licensed clinician if you have any questions about this arrangement. Your signature below indicates that you have been informed of this arrangement and that you consent to receive services from an unlicensed, supervised clinician.

Client Name/Signautre_____

Client Guardian/Signature_____

Date_____

Clinician Name_____

Clinical Supervisor Jennifer Fenton, LMFT 51078
Phone Number 831-582-1017

EHC Payment Options

Here at the Equine Healing Collaborative, we believe in building stronger communities and individuals through the use of Equine Assisted Psychotherapy. In order to ensure this, we have created a form with several payment options.

Please check one:

⚪ Sliding Scale: Please check the line item most consistent with your net income and see how much each EAP session will cost, (circle cost below). If you choose the sliding scale option, payments will be accepted via credit card, cash or check.

⚪ Superbill: You pay your clinician upfront and your clinician will provide you with a "Superbill" to provide to your insurance company for reimbursement.

⚪Scholarship: Please talk with your clinician.

⚪Blue Shield - Out of Network: Please provide insurance information below, the EHC will submit billing, and you will pay the EHC the estimated costs based on your plan (including co-pay) and your insurance company will reimburse you directly. **Please Note:** If you choose this option, it may take a month or more to get the EOB from your insurance plan so that we know exactly what we can charge you, and you may end up with a large cash bill.

⚪ Medi-Cal/Beacon/Carelon/Central Coast Alliance: Please provide insurance information and number below and we will bill directly for your session.

Please Note: It is your responsibility to notify your clinician of any changes to insurance or payment information as soon as possible in order to avoid a large bill for services.

Net Monthly Income	Cost per Session
0.00 to 3000.00	50.00
3000.00 to 3500.00	65.00
3500.00 to 4000.00	75.00
4000.00 to 4500.00	85.00
4500.00 to 5000.00	100.00
5000.00 to 5500.00	115.00
5500.00 to 6000.00	140.00
6000.00 to 6500.00	160.00
6500.00 to 7000.00	200.00
7000.00 and above	240.00

Insurance Information

Primary Insurance Name: _____

Member ID: _____

Billing Address _____

City _____ Zip_____

Secondary Insurance Name: _____

Member ID: _____

Credit Card Information

Credit Card Number _____

Expiration Date _____

Billing Address _____

City _____ Zip_____

Card Security Code _____

Signature Authorizing Use of Credit Card _____

Please Note: For cash pay clients, your credit card will be charged the agreed upon amount after each session and your card will be securely held in your electronic health record, until you notify your therapist about any change needed for payment. If the EHC has an issue with billing for any reason, the therapist will connect with the client or their guardian to notify them of the situation.

The Equine Healing Collaborative Intake

Name: _____

Date of Birth: _____ Gender: _____ Pronouns:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Personal Phone Number: _____

Preferred Email Address: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

(If under the age of 18) Guardian Name: _____

(If under the age of 18) Guardian Phone Number: _____

What brings you to The Equine Healing Collaborative?

_____
_____
_____

How long has your current problem been bothering you?

_____
_____

Have you ever been psychiatrically hospitalized? If so, why and when?

_____
_____
_____

Have you ever had any mental health services with a psychotherapist, psychiatrist, school counselor, or other type of counselor? If so, please describe:

_____
_____
_____

What is the scariest thing that has ever happened to you?

_____
_____
_____

Have you ever had thoughts/feelings/planned to harm yourself or someone else? If so, please describe:

_____
_____
_____

Has anyone in your family been diagnosed with a mental health issue? If so, please describe:

_____
_____

Who do you currently live with?

_____

Who do you primarily rely on for support?

_____

Are you taking any medications, vitamins and/or supplements? If so, please list:

_____
_____
_____

Name of Primary Care Physician:

_____

Date of your last appointment and what was it for:

_____

Do you have any medical conditions? If so, please describe:

_____
_____

Have you ever, or do you now, use any substances? If so, how long and what kind?

_____
_____

Has anyone in your family ever used substances? If so, how long and what kind?

_____

_____

Please list any hobbies you have:

_____

_____

What are your cultural, spiritual, or religious beliefs that have had an impact in your life if any?

_____

_____

What would you describe as your main strengths?

_____

_____

Have you ever had any legal issues/arrests? If so, please describe:

_____

_____

Describe your school/work past and present:

_____

_____

Do you have an IEP or 504 Plan? If so, please explain what accommodations you receive:

_____

_____

What is a goal you would like to achieve while here?

_____

_____

_____

_____

Is there anything else you would like us to know about?

_____

_____

_____

Please Initial below

Instructions For Your Intake Session:

- Please arrive on time, or 15 minutes early if you are unable to print out the paperwork ahead of time.
- Please park in the guest parking area and stay by your car until your clinician comes to greet you.
    - If you need the intake packet upon arrival, please text your clinician's cell phone number to let them know you have arrived and need the paperwork.
- All minors will need at least 1 parent or guardian to be with them during the first ½ of the intake to go over the paperwork.

Initial _____

Site Rules:

- All personal pets must stay in your vehicle at all times for their safety.
- No smoking on property of any kind including vaping.
- All guests must stay in their cars or in the parking lot area.
- No photos or video can be taken of clients unless they have given permission and are in the parking lot area for their privacy and the privacy of others.

Initial _____

Addresses and Directions:

- Mailing address: PO Box 1087, Monterey, CA 93942

- Bella Tierra Ranch (main site): 902 Monterey Salinas Highway, Salinas CA 93908
    - When arriving from Salinas, please pass the ranch and turn around at the Pasadera/Boots Rd. stoplight. DO NOT TURN LEFT ACROSS TRAFFIC to enter the property. Enter the property from the right side under the red arch.
    - When arriving from Monterey, pass the Passadera/Boots Rd. stoplight and the entrance will be on the right under the red arch.
- Deerhorn Ranch (Felton): 160 Deerhorn Ln, Felton, CA 95018
    - Turn left onto Deerhorn lane from E Zayante Rd, go past where google maps shows and you will see the entrance on the left hand side. Look for the white fence.
- Flying Pig Ranch (Prundale): 10101 Equestrian Place, Salinas, CA 93907
    - When arriving from 101 North, take Reese Rd. to Blackie Road. Turn left at Equestrian Estates. Last house in the cul-de-sac of Equestrian Place.
    - When arriving from Castroville, take Blackie Road, then a right turn at equestrian estates. Last house in the cul-de-sac of Equestrian Place.

All sites are by appointment only, and the homes on all 3 properties are private and employee only. No entry at any time.