**Client Service Agreement & Consent**

|  |  |
| --- | --- |
| Client Name: Click here to enter text. | Date of Birth: Click here to enter text. |
| Parent/Guardian Name: Click here to enter text. | NDIS No: Click here to enter text. |
| Address: Click here to enter text. | |
| Email: Click here to enter text. | Mobile No: Click here to enter text. |
| EAT/HPR package/sessions: | Hourly Fee: |
| Support start date: Click here to enter text. | Support End/Review Date: |
| Session Duration: Click here to enter text. | Frequency: Click here to enter text. |
| Account Name: BJ Pearce & RC Muckleston | Bank Name: NAB |
| BSB No: 085-762 | Account No: 743664238 |
| Reference: PLEASE USE INVOICE NUMBER FOR REFERENCE | |
| Name of NDIS Plan Manager: Click here to enter text. | |
| Email for Invoice: Click here to enter text. | |

**Cancellation Policy: Rescheduling or cancelling must be done 48 hours before the planned date to avoid a full fee charge, as per Bellview Connection Cancellation Policy.**

***Consent Form for Equine Assisted Psychotherapy and Nature-Based Walk and Talk Therapy***

**Services and Risks:**

I, the undersigned, hereby consent to participate in Equine Assisted Psychotherapy and Nature-Based Walk and Talk Therapy sessions offered by Bellview Connection. I understand that these therapies involve interaction with horses and outdoor activities, and as such, carry inherent risks. These risks may include, but are not limited to:

1. **Physical Risks:** Injuries may occur due to the unpredictability of horses or natural elements during outdoor sessions.
2. **Emotional Risks:** Engaging in psychotherapy may bring about emotional challenges and discomfort.
3. **Confidentiality Risks:** Despite our commitment to confidentiality, the outdoor setting may present challenges to privacy.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Client, Parent or Guardian Signature |  | Date |
| Click here to enter text. | | |
| Client Name (Please Print) Click here to enter text. | | |

****

**Confidentiality and Privacy:**

I understand that confidentiality is crucial for effective therapy. However, I acknowledge the following considerations:

1. **Limits to Confidentiality:** There may be exceptions to confidentiality, such as instances where there is a risk of harm to myself or others.
2. **Nature-Based Setting:** While every effort will be made to ensure privacy, the outdoor setting may present challenges to maintaining confidentiality.
3. **Third-Party Involvement:** With my consent, specific information may be shared with involved parties for the purpose of collaborative care.

**Consent for Treatment:**

I willingly consent to participate in Equine Assisted Psychotherapy and Nature-Based Walk and Talk Therapy sessions. I acknowledge the risks involved and understand that the therapist and staff will make every effort to minimize these risks.

**Emergency Medical Treatment:**

In the event of a medical emergency, I authorize Rachael Muckleston or designated staff to obtain necessary medical treatment on my behalf. I understand that efforts will be made to contact me or my emergency contact before any medical decisions are made.

**Agreement:**

I have read and understood the information provided in this consent form. I am aware of the risks associated with Equine Assisted Psychotherapy and Nature-Based Walk and Talk Therapy and voluntarily choose to participate. I understand the importance of wearing a helmet, securely fastened with a harness, at all times when mounted at the Bellview Connection facility. I acknowledge the existence of Bellview Connection's Barn Rules and agree to adhere to them strictly during each visit.

**Agreement Validity:**

This agreement shall remain in effect for each visit to the Bellview Connection facility. The terms of this release form constitute the entire agreement and may not be altered, amended, or modified except in writing and signed by both parties. The terms of this release are governed by the laws of Victoria, Australia.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Client, Parent or Guardian Signature |  | Date |
| Click here to enter text. | | |
| Client Name (Please Print) Click here to enter text. | | |



**Consent to Therapy**: To provide quality assessment and therapeutic services, Bellview Connection will collect and record personal information relevant to your situation.

**Information Handling Purpose:** Personal information collected during assessment and treatment is stored securely and used exclusively by your Consultant and authorized practice personnel. It is retained to document session details and support your Consultant

**Access to client information**

You are entitled to access your personal information kept on file, unless relevant legislation states otherwise. If you require access to your information please discuss this with your Consultant.

**Disclosure of personal information**

Personal information gathered by your Consultant during the provision of services is considered confidential and will not be disclosed to another party except when:

* your prior approval has been obtained to:
* a)    Provide a written report to another professional or agency. Eg. a Doctor or a Lawyer; or
* b)    Discuss your care with another person, egg. a Parent, Employer or Health Care Provider; or
* it is subpoenaed by a court; or
* Failure to disclose the information would in the reasonable belief of your Consultant place you or another person at serious risk of harm; or disclosure is otherwise required by law.

**Photo Release**: Consent to use photographs and audio/visual materials for promotional purposes

*[Consent*] Yes / No

**Signatures**: Click here to enter text. Date: Click here to enter text.

Mutual Agreement: Both parties agree to abide by mutually agreed time frames, honour commitments, and develop an open, honest, and trusting relationship.

Procedure:

* Return signed and dated Client Service Agreement & Consent Form via email.
* Return completed Client Intake Form via email
* Book a session at least 48 hours in advance https://calendar.app.google/9HozsXYiPkNbxRv66
* Confirmation 24 hours prior to the session.

*Note any allergies or conditions*…Click here to enter text.…

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Client, Parent or Guardian Signature |  | Date |
| Click here to enter text. | | |
| Client Name (Please Print) Click here to enter text. | | |