Coastal Synergy
ASSOCIATES

Client Name: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

_____**I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.**

I have received, read and understand Coastal Synergy Associates' Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I understand that Coastal Synergy Associates has the right to change the Notice of Privacy Practices from time to time and that I may contact Coastal Synergy Associates to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that Coastal Synergy Associates restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Coastal Synergy Associates is not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions.

OFFICE POLICIES ACKNOWLEDGMENT

_____**I have read the Office Policies & Agreement for Clinical Services; I understand them and agree to comply with them.**
_____**I understand confidentiality and its limits, including limits for minors, groups, and outside environments.**
_____**I understand the E-mail, cell phone, fax, and emergency policy/procedure.**
_____**I understand the record request procedure.**
_____**I understand the fees, payment, cancellation policy, no-shows fees, court fees, document fees, phone call fees and insurance limitations.**
_____**I understand that I am entering into this counseling relationship voluntarily and I or my counselor can terminate this relationship at any time.**

HEALTH INSURANCE INFORMATION AND ACKNOWLEDGMENT
Health Insurance Data & Assignment

Social Security Number: _____Date of Birth: _____

Primary Insurance: _____

ID #: _____ Group #: _____

Subscriber (Guarantor) Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ City:_____ State:_____Zip:_____

Subscriber Employer: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

Subscriber (Guarantor) Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ City:_____ State:_____Zip:_____

Subscriber Employer: _____

_____**I hereby authorize the release of any medical information necessary for the processing of insurance claims. I hereby assign all medical benefits to which I am entitled, to Coastal Synergy Associates. This assignment will remain in effect until revoked by me in writing.**
_____**I understand that Coastal Synergy Associates will bill my insurance company as a courtesy but the responsibility for payment is mine. I agree that if my insurance company does not remit payment to Coastal Synergy Associates within 60 days, that I will pay my account.**
_____**I understand that insurance companies require that Coastal Synergy Associates provides a mental health diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders (ICD-10) in order to receive payment for services. These diagnostic codes can remain in your insurance file for a very long time and may impact your ability to acquire insurance in the future, so please feel free to discuss this issue with Coastal Synergy Associates to gain a better understanding of the diagnosis you've.**

Client's Name or Guardian (If minor)_____

Signature _____ Date _____

Guardian Name (if applicable):_____

Relationship to Patient:_____

Signature_____

Date _____

EXPRESSIVE THERAPIES/EQUINE THERAPY RELEASE OF LIABILITY

Here at Coastal Synergy Associates, safety is our number one priority in the facilitation and management of all types of counseling techniques. However, even with the appropriate training and risk management practices in experiential programming and animal-related activities, accidents do occur. The level of participation in our programs is entirely voluntary and under individual choice at all times and for ALL aspects of the programming or training.

VOLUNTARY RELEASE OF LIABILITY
I am over 18 years of age. I assume full responsibility for myself and/or my child(ren) for all risks, inherent and otherwise, related to attendance and participation in this program sponsored by Coastal Synergy Associates, LLC. By signing this release form, I agree to release and hold harmless Coastal Synergy Associates, its agents, assistants, employees, facilitators, all individuals assisting in instructing and conducting these activities, and co-sponsors including but not limited to their employees or agents, all shareholders, officers, members or partners (collectively known as Releasees), for any damage or injuries, physical or mental, which I and/or my minor child(ren) might incur as a result of my voluntary decision to participate in this program.

By signing this release form, I agree that if I (or my minor child) do(es) sustain any physical injury or mental damage of any nature as a result of my voluntary decision to participate in the program, on behalf of myself, my children, my heirs, my personal representatives and next of kin, I hereby release and discharge Releasees and their successors, assigns, affiliates, directors, officers, employees, members, partners and agents from any and all liabilities, claims, lawsuits, losses, costs, causes of action, and damages of any kind originating in any way arising from my or my children's participation in activities (Even if such claim is due in whole or in part to the negligence of Releasees and their successors, assigns, affiliates, directors, officers, members, partners, employees and agents). The foregoing release includes a release of Releasees and their successors, assigns, affiliates, directors, officers, members, partners, employees and agents for their own negligence.

In the event that any of my children, guests, or other third person shall assert any claim whatsoever kind against the Releasees, their successors, assigns, affiliates, directors, officers, members, partners, employees and agents, arising out of or related in whole or in part to any negligent act or omission by me in connection with program activities, I agree to indemnify and hold harmless the Releasees, their successors, assigns, affiliates, directors, officers, members, partners, employees and agents from any such claims and any related liabilities, obligations and

expenses, including attorney's fees and other costs of investigation and litigation. I assume full responsibility for myself and/or my minor child(ren) and guests for bodily injury, death, loss of personal property, and expenses thereof, as a result of my negligence, or other risks, including but not limited to those related to participation in any aspect of this program for the full duration of my participation in this program.

I acknowledge that I have been given the opportunity to ask questions regarding any aspect of this release form and by signing in the space provided do acknowledge that I have read completely and fully understand all aspects of this release form and agree to its terms in their entirety. I have been informed of the full nature of this program and its inherent risks and fully understand the nature of the program.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES

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 facility, I authorize therapists or employees of Coastal Synergy Associates to:

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

Physician's Name:_____

Preferred Medical Facility:_____

Insurance Carrier:_____

Designated Person:_____ Phone:_____

CONSENT PLAN
This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date:_____ Consent Signature:_____

Name (Print):_____

If Parent/Guardian list relationship:_____

Print Name:_____ Phone:_____

Address:_____

NON-CONSENT PLAN

I do not give 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 facility. In the event emergency treatment/aid is required, I wish the following procedures to take place:_____

_____

Date:_____ Consent Signature:_____

Name (Print):_____

If Parent/Guardian list relationship:_____

Print Name:_____ Phone:_____

Address:_____