PERSONAL INFORMATION FORM – ADULT

Please fill in the information below and bring this form with you to your first session. NOTE: information provided on this form is protected as confidential information.

BASIC INFORMATION:

NAME:_____

ADDRESS:_____

MAILING ADDRESS:_____

Home Phone:_____ May we leave a message?_____
Cell Phone:_____ May we leave a message?_____
Home Phone:_____ May we leave a message?_____
Email Address:_____ May we send email here?_____
**Please note: Email is not considered to be a confidential medium of communication.*

DOB:_____ AGE:_____ GENDER:_____

MARITAL STATUS:
Never Married_____ Domestic Partnership_____ Married_____
Separated_____ Divorced_____ Widowed_____

SPOUSE'S NAME:_____

EMERGENCY CONTACT: _____
NAME PHONE #

PERSON RESPONSIBLE FOR PAYMENT:_____ DOB:_____

PERSON WHO REFERRED YOU (if any):_____

May I send a note of thanks for the referral ( ) Yes ( ) No

MENTAL HEALTH HISTORY

•Have you previously received any mental health services (psychotherapy, psychiatric, etc.)?
_____No _____Yes, previous therapy/practitioner_____

•Have you ever been and/or are you currently taking prescribed psychiatric medication?
_____No _____Yes
If yes, please list medication name and dates taken:
_____
_____

•Have you ever contemplated or attempted suicide?

_____No _____Yes

Therapist:_____

If yes, when? _____

•Have you ever contemplated or intentionally harmed another person?

_____No _____Yes

If yes, when? _____

GENERAL PHYSICAL AND MENTAL HEALTH

•How would you rate your current physical health? (Please circle one.)

Poor Unsatisfactory Satisfactory Good Very Good

•Please list any specific health problems you are currently experiencing:_____

_____

•Date of last physical_____

•Family Physician:_____ Phone:_____

•Physical Disabilities or Limitations: _____

•Current Medications: _____

•Injury/Illness/Allergies:_____

•How would you rate your current sleep habits? (Please circle one.)

Poor Unsatisfactory Satisfactory Good Very Good

•Please list any specific sleep problems you are currently experiencing:

_____

_____

•How many times per week do you generally exercise? _____

•What types of exercise do you participate in? _____

•Please list any difficulties you experience with your appetite or eating problems: _____

_____

•Are you currently experiencing any anxiety, panic attacks or have any phobias? No_____Yes____

If yes, when did you begin experiencing this? _____

•Are you currently experiencing any chronic pain? No____Yes____

If yes, please describe:_____

•Substance use? (Alcohol, Tobacco, Illicit Drugs) No____Yes____

If yes, what, when, and/or how often? _____

_____

•Are you currently in a romantic relationship? No____Yes____If yes, for how long? _____

Therapist:_____

•What significant life changes or stressful events have you experienced recently? _____

_____

_____

PLEASE RATE THE FOLLOWING 1-5 (1=AWFUL and 5=GREAT):

Work____ Family Relationship_____ Peer Relationship_____

Romantic Relationship_____ Overall Happiness _____

FAMILY HEALTH	**Please Circle**		**List Family Member**
Alcohol/Substance Abuse	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____
Domestic Violence	Yes	No	_____
Eating Disorder	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____
Suicide Attempts	Yes	No	_____

CHECK ANY YOU HAVE EXPERIENCED IN THE PAST WEEK:

Anger____ Fear____ High Energy____ Sadness____ Tension ____

Concerns about body _____ Repetitive Thoughts/Behaviors____

PLEASE COMPLETE THE FOLLOWING SENTENCES:

Some of my strengths are_____

Some of my weaknesses are_____

Fun for me is_____

I came here today_____

What would you like to accomplish in therapy?_____

_____

Therapist:_____

ADDITIONAL INFORMATION

•Are you currently employed? No____Yes____ If yes, what is your current employment situation:_____

•Do you enjoy your work? No____ Yes____

•Is there anything stressful about your current work? No____Yes____ If yes, please describe?_____

•Do you consider yourself to be spiritual or religious? No____Yes____ If yes, describe your faith or belief:_____

ACKNOWLEDGEMENT AND AGREEMENT:

When scheduling an appointment, I agree that I have contracted for that time. I understand that twenty-four (24) hours' notice is required in order to cancel my appointment (Monday morning appointments must be canceled no later than the previous Friday morning). For the therapist to maintain consistency from one client to another and to maintain flexibility to be able to meet with clients, I understand that THERE WILL BE NO EXCEPTIONS. If I do not cancel an appointment within this time frame, I will be charged for the session **(payment must be made before further sessions will be scheduled).**

Should I decide to access my "out of network" insurance benefits (if available), I understand I am responsible for filing my insurance claims. I understand that I am ultimately responsible for any and all expenses accrued and that payment is due and will be made when services are received. If additional information is needed, I authorize a Tranquil Hearts Counseling Center therapist to release any medical or necessary data to process my insurance claims, and I accept responsibility for charges for this service.

I signify all information regarding the therapist's policies and procedures such as my rights as a client/responsible party, risks and benefits of services, confidentiality, emergencies, payment, and insurance have been discussed with me to my satisfaction. I attest I have received a copy of the Informed Consent, and that I comprehend all information. My signature below acknowledges acceptance of these policies and procedures, and my agreement to enter therapy (or for my dependent to enter into therapy) with a therapist from Tranquil Hearts Counseling Center.

_____ _____
Client Date

_____ _____
Therapist Date

I testify that to the best of my knowledge, the information provided above is accurate and complete. I further grant permission for my therapist to consult and share, should she deem it necessary,

Therapist:_____

pertinent information concerning me with other professionals in order to aid my counseling/growth process.

_____ _____

Client Date

INFORMED CONSENT – PRIVACY POLICY –
THERAPY AGREEMENT

Welcome! This document answers many questions clients often ask about therapy and explains procedures, expectations, and privacy policy. After reading and fully understanding its contents, you will be asked to initial each page and sign the agreement. Please retain a copy for your records/reference.

SESSION FEES:

Intake (75 minutes) **$175** Couple/Family (90 minutes): **$190** Individual/Child (60 minutes): **$150**

All professional time will be billed for at a rate of $2 per minute. This includes writing or reading reports or letters on your behalf, scoring of rating scales/evaluations, consultation/phone calls, email communication, extended sessions, copying/mailing of records, off-site observations (including travel time), etc. While there is no charge for calls to schedule/change appointments, inquire about services, etc., after hours consultation calls are charged 150% of the usual rate.

Your session time is for you and is taken seriously. *You are contracting for the time you have scheduled.* Please make every attempt to attend your scheduled sessions and arrive on time. **Twenty-four (24) hours notice is required in order to cancel an appointment.** To maintain consistency from one client to another and to maintain flexibility to be able to meet with clients in a timely manner, *exceptions (excluding unavoidable emergencies) will not be made.* If an appointment is not canceled 24 hours in advance, **you will be charged for the session.** This helps to eliminate "No Shows" and ensures maximum appointment availability for you.

PAYMENT:

Payment in full for all professional services is due at the time of the service. You (or parent/guardian) are directly responsible for payment. Fees may be adjusted individually, based on the needs of the client when agreed upon by the provider. **Checks should be made payable to your individual therapist. Credit cards and cash are also accepted.** It is helpful to have checks made out before the session begins. **Returned checks are subject to a $35 service fee which must be paid prior to the next appointment, and future payments will be required to be made with cash or money order.** Because payment is due when services are rendered, we usually do not send bills. If, however, a situation necessitates that you be billed, please remit payment within five days of receiving the invoice. Should payment problems arise, they must be worked out openly and quickly. Such problems can greatly interfere with counseling/therapy progress and our working relationship.

Insurance: Your health insurance policy is a contract between you and your insurance company. We do not contract with insurance companies to be one of their network providers and are not a party to your specific contract. You may be eligible for "out of network" benefits, but will need to research the extent of your coverage to make this determination. Insurance benefits may only apply to the counseling/therapy services which we provide as a Licensed Professional Counselor. You are responsible for completing and filing the necessary paperwork for insurance reimbursement. We will provide you a receipt for services rendered. Please let us know if you intend to access your insurance benefits as additional information, such as a specific diagnosis, if determined to be present, is usually required. You are also responsible for keeping track of your benefit requirements/limitations such as the number of sessions allowed per calendar year, authorized time periods, and so on. Please be aware we have no control or responsibility for confidentiality procedures employed by your insurance company. Should you choose insurance as an option, we may be required to provide the company with your personal health information, which includes history as well as current status, for you to be reimbursed. You must give written permission for the release of your personal health information.

CONFIDENTIALITY:

All information shared in session is held in strictest confidence according to federal regulations. The following are exceptions: 1) Legal obligation such as child or elder abuse, court subpoena, cooperating with law enforcement officers, etc., 2) Suspected personal danger to yourself or an identifiable victim, 3) Information required by insurance companies for payment (for which you consented), 4) Information provided to parents if the client is a minor, 5) Valid collection of a debt, and/or 6) Consultation with other professionals in order to aid in the counseling/therapy process (identifying information will be withheld unless written permission is given). Release of information to other individuals, agencies, or professionals may only be done with your written consent.

OFFICE HOURS/APPOINTMENTS:

Contact your individual therapist for office days and times. You may ask to have the same time each week for your appointment. We will do our best to accommodate your request, as certain time slots are in demand and fill quickly.

When in session with a client, we will not be able to take phone calls. Please leave a message on our individual voicemail. We make every attempt to return calls daily. Emergency calls may be taken after hours and charged the 'after hours' rate. As we honor and value our personal self-care time and time with family, we ask that you limit after hour calls to emergencies only.

EMERGENCIES:
As a rule, our practice is not crisis oriented in nature. If you feel you will need more intensive after hours support on a regular basis, please inform us during our first session. We will be happy to help you locate a provider whose practice is more suited to on-going crisis intervention.

For an emergency, please attempt to contact your individual therapist. If we cannot be reached immediately by phone, you, your family member, or friend should call the **HOUSTON CRISIS HOTLINE at 713-468-5463, DIAL 911, or GO/BE TAKEN TO THE NEAREST HOSPITAL EMERGENCY ROOM.**

LEGAL MATTERS:
Should you ever become involved in a divorce or custody dispute, **we will not provide evaluation (written or otherwise) or expert testimony in court.** You should hire a different/neutral mental health professional for any evaluation or testimony you require. This position is based on two main reasons: 1) Our statements will be seen as biased in your favor because we have a counseling/therapy relationship, and 2) the testimony may affect the counseling/therapy relationship, and we must put this relationship first. This applies to all clients regardless of age.

If, as part of your session work, you create/provide to us records, notes, artworks, or any other documents or materials, we will return the originals to you at your written request but will retain copies. You have the right to review or get copies of your personal health information with limited exceptions. You must submit a written request and allow a reasonable time period (maximum of 30 days) for compliance. If you are concerned that we have violated your privacy rights, or disagree with a decision we have made in regards to access to your personal health information, please inform us immediately. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Violations: In our practice we follow the professional code of ethics of the American Counseling Association. Any violations of the Licensed Professional Counselor Act should be reported to: Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, TX 78756-3183, 512-834-6658.

ABOUT THERAPY:
Seeking help through counseling/therapy is a wonderful way to gain new clarity as well as obtain practical tools to support you in your daily living and in navigating life transitions. Because you will be investing time, energy, and money, it is important to choose a therapist with whom you are comfortable.

Our work together will focus on wellness and increasing overall life satisfaction. Utilizing a problem-solving/skill-building approach, we will work together to identify developmental and/or life issues and concerns with which you may be dealing *and* useful skills to help you address your problems. We will devise a plan to help you incorporate your new skills into your daily living. Homework may be assigned which you will be asked to complete as a means of moving toward the achievement of your goals.

Although no counselor/therapist can ethically guarantee achievement of goals, it has been our experience that the more you put into the process, the better the chance for positive, lasting results. Because the work that we do *is* a process and often has a cumulative effect, *it can be helpful to commit to a minimum number of at least six sessions.*

While you most likely will experience gains in as little as one session, it generally takes longer for deeper work. You or your therapist have the right to terminate this agreement at any time. At least one session's notice is helpful for all involved, should the decision to terminate, by you or by the therapist, occur. This allows for closure. If needed, you will be provided the names and phone numbers of other qualified counselors/therapists.

The Benefits and Risks of Counseling/Therapy: There may be some risks as well as many benefits with counseling/therapy. You should think about both the benefits and risks when making any treatment decisions. For example, there is a risk that you will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other such feelings. You may recall unpleasant memories which may bother you in settings outside of our sessions. You may receive feedback from some people who mistakenly suggest participating in this process is a sign of weakness. (By the way, we believe investing in your personal growth is a sign of courage and strength!)

Therapist:_____

Also, this process has the potential to impact your relationships with people who are important to you such as members of your family. You may experience a temporary worsening of problems after beginning, although this usually passes as you learn new skills and increase your self-confidence in applying them. Most of these risks are to be expected when making important changes in your life. Finally, even with our best efforts, there is a risk that counseling/therapy may not work out well for you.

While you consider these risks, you should also know the benefits of counseling/therapy have been scientifically researched and validated. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. Through this work, you will have a chance to talk things out fully until your feelings are relieved or your problems are solved. Your relationships and coping skills may improve greatly, increasing your overall satisfaction. Your personal goals and values may become clearer. You may find yourself growing in many directions and experience an increased ability to live authentically and fully enjoy your life.

What to Expect from Our Relationship: Services are best provided in an atmosphere of trust. You expect us to be honest with you about your problems and progress, and we expect you to be honest with us about your expectations for services, your compliance with medical advice from your doctor, and any other treatment issues. As a Licensed Professional Counselor (LPC), we will use our best knowledge and skills to help you achieve your goals. Our duty is to care for you and my other clients, but *only* in the professional roles of counselor/therapist. Ethically, we are bound to avoid "dual relationships." We are not able to advise you from other professional viewpoints such as law, medicine, finance, etc. We must honor confidentiality (excluding the areas mentioned below as confidentiality exceptions). To maintain privacy, we do not reveal the identities of our clients without their consent. Therefore, if we meet on the street, we may not say hello or talk to you very much. *This would not be a personal reaction to you, but rather an effort to maintain the confidentiality of our relationship.* Lastly, we cannot socialize or have a romantic relationship with any of our clients, and cannot provide counseling/therapy to any family members or friends.

AGREEMENT:

I, _____, confirm that I have read, or have had read to me, in its entirety, this document. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the policies and procedures listed in this document. I understand that no specific promises have been made to me by the therapists at Tranquil Hearts Counseling Center, about the results of treatment, the effectiveness of the procedures used by them, or the number of sessions necessary for therapy to be effective. I understand that after therapy begins, I have the right to withdraw my consent at any time, for any reason. I will make every effort to discuss my concerns about my progress with my therapist before making the decision to end therapy.

I hereby agree to enter into a professional working relationship, as detailed above, with a Tranquil Hearts Counseling Center therapist, (or to have my minor child enter), and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ _____

Signature of Client (Parent/Guardian) Date

Having met and discussed with this client (and/or client's parent/guardian) the policies and procedures outlined in this document and having responded to all questions posed, we believe this person fully understands the information presented. We find no reason to believe this person is not fully competent and capable, legally or otherwise, to give informed consent. Therefore, we, Tranquil Hearts Counseling Center therapists, agree to enter into a professional working relationship, as detailed above, with this client as shown by our signature here.

_____ _____

Signature of Therapist Date

Erin Silva, M.Ed., LPC
Tranquil Hearts Counseling Center
16712 Huffmeister Rd, Building 400B
Cypress, TX 77429
(281)433-1363

AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize Erin Silva, M.Ed., LPC and

_____
(Name of person(s) or organization(s) which disclosure is to be made to and/or received from)

_____ _____
(Address) (Phone Number)

to disclose or release **one to the other** the following information from my records:

_____ All Health Care Information
Initials

_____ Health Care Information or Opinions Relating to any or all of the following treatment(s) and/or conditions:
Initials

_____ 1. Psychiatric or Mental Health Information
Initials

_____ 2. Academic and Confidential School Information
Initials

_____ 3. Testing
Initials

_____ 4. Other _____
Initials

For the purpose of treatment/management and/or supervision or psychological and/or medical conditions(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

_____ _____
PATIENT DATE

_____ _____
PARENT OR LEGAL GUARDIAN DATE

Tranquil Hearts Counseling Center

16712 Huffmeister Rd, Building 400B
Cypress, TX 77429

Erin Silva (281)433-1363
Julie Casten (773)329-7556
Alison Lampton (832)630-0777
Jessica Jensen (832)229-4102

Pre-Authorization Charge Form

I authorize Tranquil Hearts Counseling Center to keep my signature on file and to charge my Credit Card listed below **for missed appointments and late cancellations.**

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Client's Name : _____

Cardholder's Name : _____

Choose Card Type : VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Account Number : _____

Expiration Date : _____

Card Verification No.: _____

Billing Zip Code : _____

Cardholder Signature: _____

Today's Date : _____

Tranquil Hearts
COUNSELING CENTER

Teletherapy Informed Consent Form

I,_____, hereby consent to engage in teletherapy with _____. I understand that "teletherapy" may include consultation, treatment, emails, or telephone conversations. I understand that teletherapy also involves the communication of my medical/mental health information both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Informed Consent – Privacy Policy Agreement which I received with this consent form.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and confidentiality cannot be guaranteed.
4. I understand that teletherapy-based services and care may not be as complete as face-to-face services, and if the therapist believes I would be better served by another form of therapeutic service (e.g.: face-to-face services) I will be referred to a professional who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that I may benefit from teletherapy, but the results cannot not be guaranteed or assured.
5. I accept that teletherapy does not provide emergency services. During our first session, the therapist and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts, or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour support.
6. I understand that I am responsible for providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions; the information security on my computer; and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions during my therapy sessions.

I have read, understand and agree to the information provided above.

_____

Signature and Date

_____

Client Printed Name

Tranquil Hearts
COUNSELING CENTER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly with appropriate authorization to share information.
- Obtain payment from third-party payers, if applicable.
- Conduct normal healthcare operations such as quality assessments and record keeping.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE:	INITIALS:	REASON:

Tranquil Hearts
COUNSELING CENTER

EMAIL AND TEXTING CONSENT

HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information (PHI) private and secure. Emails and texts are very convenient ways to handle administrative issues like scheduling or receipt requests, but email and texts are not 100% secure. Some of the potential risks you may encounter if we email or text include:

- Misdelivery of email/text to an incorrectly typed address.
- Email/text accounts can be "hacked", giving third party access to email/text content and addresses.
- Email/text providers (i.e., Gmail, Yahoo, etc.) keep a copy of each email/text on their servers, where it may be accessible to employees, etc.

For these reasons, I will not use email/text to discuss clinical issues (i.e., important things we talk about in session). If you are comfortable doing so, I am happy to use email/text (text for appointment reminders only) to handle small administrative matters like scheduling and billing. If you are not comfortable with these risks, we may handle administrative issues via phone calls.

Please indicate your preference about email/text below and sign.

_____ (initials) I do consent to use of email and/or text for administrative matters.

_____ (initials) I do not consent to use of email and/or text for administrative matters.

If given, consent will expire 2 years after our last appointment. Please remember reminders will be sent only via emails or texts. I will respond to you briefly via email but never text.

Patients Printed Name: _____

Relationship to Patient: _____

Signature: _____

16712 Huffmeister Rd, Bldg 400A, Cypress, TX 77429; 281-433-1363

Erin Silva, M.Ed, LPC, ICST

Interactions with Therapy Dog: Informed Consent, Release and Waiver

INTRODUCTION:

Louie was born on August 16, 2019. He is a 24-pound white Cockapoo, which is a mixed breed between a Cocker Spaniel and a Poodle. I rescued him at three months of age, and Louie has received numerous behavioral training courses over the last three years. He loves people of all ages, to give hugs and play fetch. Louie can walk on his hind legs and shake. He is a very calm, sweet, and loving dog.

RISKS AND BENEFITS:

There are many benefits associated with working with therapy animals. Some benefits that have been found in utilizing therapy animals include:

- Animals help improve motivation and engagement in therapy.
- Animals provide a sense of security and emotional support. Dogs offer unconditional acceptance and positive regard.
- Animals can promote relaxation. Research has demonstrated that petting an animal can help lower blood pressure, heart rate, and increase oxytocin (a feel-good chemical in the brain).
- Animals can help the client learn frustration tolerance and other anger management techniques.
- Animals can help in the areas of focus and attention.
- Animals can be instruments of learning, which can increase self-confidence and self-esteem.
- Animals offer humor and fun due to their playful nature.
- Animals in therapy ask for clients to develop empathy, nurturance, and responsibility, and model other skills like forgiveness and patience.

Even though there are many benefits to working with therapy animals, there are risks involved in utilizing this method of therapy. For example: dogs may nibble, accidentally scratch, lick, lean up against a client, and/or cause light bruising. These actions are not aggression but rather the dog's way of interacting with the client. In addition, if the client is allergic to dogs or is unaware of an allergy, the client may suffer from an allergic reaction.

ASSESSMENT:

Working with a therapy dog in training may not be appropriate for each client or at every session.

Its use will be determined on a case-by-case basis. In the following circumstances, working with Louie will not be used or will cease:

1. If the client has a history of animal abuse/cruelty, or there are other risk factors that indicate potential harm to Louie.

2. If the client has a known allergy to dogs or an unknown allergy becomes known during therapy.

3. If the client exhibits problematic behavior toward Louie, including but not limited to: kicking, biting, pushing, hitting, pulling the tail/ears/paws, and/or pinching Louie.

4. If the client has a fear of animals and the scope of the client's therapy is not meant to address that fear.

ALLERGIES:

The client shall inform Erin of any and all known allergies. Louie may be at Erin's office every day. Although a specific client may not be interacting with Louie, he will still be present in Erin's office. If the client has an allergy to Louie, Erin will then determine whether any arrangements may be made to accommodate the allergy.

ACCIDENTAL INCIDENTS:

If Louie accidentally scratches, nibbles, or otherwise causes any harm to the client, the client agrees to notify Erin immediately.

INTERACTIONS WITH LOUIE:

Dogs interact with humans differently than when humans interact with each other. Dogs wag their tails, lick people, may lean up against a person's leg, or lay near a client. This is how Louie interacts with humans. If the client is uneasy or otherwise uncomfortable with how Louie interacts with him/her, client agrees to express those concerns immediately to Erin.

If a client prefers that Louie be in his crate during sessions, please let Erin know beforehand.

CONDUCT TOWARD LOUIE:

1. Just like a human being, Louie should be treated with respect and kindness. If Louie is sick or injured, he will not actively be working, however, therapy services will continue. Louie will obtain veterinary approval prior to resuming work if he is sick or injured.

2. Erin is also required to look out for the general welfare and safety of Louie. If at any time Louie becomes irritated, frightened, distressed, or in any way exhibits a negative and/or aggressive behavior,

he will take a break. If this occurs, only Erin may interact with Louie until in Erin's sole and absolute discretion he is able to return to the session.

DISEASE:

Every effort will be made to ensure against zoonotic disease transmission (i.e. the sharing of disease between humans and animals). Louie will remain current on all standard vaccinations, such as rabies; however, there is always a risk of the transmission of a disease when working with animals. A client may request to review a list of vaccinations for Louie.

RELEASE AND WAIVER:

I, _____ hereby agree for myself and/or my minor child to hold Erin Silva harmless from any and all claims and/or damages (including medical fees and attorney fees) and causes of action of any nature for any and all personal and/or bodily injury or illness, which may occur to myself or my minor child, or which may be aggravated or caused by the negligence of others while interacting with Louie.

ASSUMPTION OF RISK: I, _____individually and/or on behalf of any minor child, specifically assume any and all known and unknown risk of injury or illness, resulting from interacting with Louie, which may include, but is not limited to: zoonotic disease transmission, scratching, nibbling, heavy leaning, jumping, light brushing, and/or licking by Erin, and any unknown or known allergic reaction.

I agree to abide by Erin's office policies and procedures as they specifically relate to Louie and his training as a therapy dog. If I have any questions as to conduct that is appropriate when interacting with Louie, I agree to ask Erin before engaging in such conduct.

If any injury and/or illness occurs while at Tranquil Hearts Counseling Center, I, individually and/or on behalf of my minor child, hereby authorize Erin to contact the medical professional listed below, or if the medical professional is unavailable or cannot be reached, to call 911 or the nearest hospital. I take full responsibility for my welfare and safety as well as for my minor child; and I hereby give permission for emergency medical treatment to be administered as deemed appropriate.

Name, Address and Phone number Information for Medical Professional:

I, individually, and/or on behalf of my minor child, being informed of the above known risks, and acknowledging other potential unknown risks, have read the above waiver and release. I understand that by signing this Agreement I, individually, and/or on behalf of my minor child am waiving certain legal rights.

_____

Client's Printed Name

_____ _____

Client/Parent/Legal Guardian Signature Date

_____ _____

Erin Silva, M.Ed, LPC, ICST Date