

**SERVICE AGREEMENT
INDIVIDUAL, COUPLE, AND FAMILY THERAPY**

Passionately Living, LLC

Therapist: Rebecca Jones, LPC, NCC

License Number: 0701009918

Please let your therapist know any questions you may have about this document prior to signing.

Welcome to Passionately Living, LLC! This document (“the Agreement”) contains important information about the professional services and business policies of Passionately Living, LLC and your therapist, Rebecca Jones, LPC, NCC. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that you are provided with a Notice of Privacy Practices (“the Notice”) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, included in this agreement, explains HIPAA and its application to your personal health information in greater detail.

Your signature on this form will indicate that you have received and read this document and that you understand it and that you agree to it. When you sign this document, it will also represent an agreement between you and Passionately Living, LLC.

WHAT IS PSYCHOTHERAPY

Psychotherapy, also referred to as mental health counseling, or counseling, is the treatment of mental illness, behavior disorders, or any other condition by psychological means. Communication and relationship factors between an individual and a trained mental health professional are central to this process. Therapists use specific psychological treatment approaches and techniques in psychotherapy. The therapy relationship has clearly defined responsibilities. Your therapist has advanced training and follows ethical and legal guidelines for their work.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to significant reduction in feelings of distress, and increased satisfaction in interpersonal relationships. But there are no guarantees of what you will experience. Psychotherapy

requires a very active effort on your part. In order to enjoy the most success, you will have to work on what you learn in therapy during your time outside of sessions.

Individual Therapy

In individual psychotherapy, you and your therapist are the only ones present in the therapy session.

Couples Therapy

In a couples' therapy session, both partners in a relationship are treated at the same time by the same therapist. Couples therapy is concerned with problems within and between the individuals that affect the relationship. Individual sessions may be provided separately to each partner, particularly at the beginning of therapy, but for most of the course of treatment, therapy is provided to both partners together.

Family Therapy

In a family therapy session, the therapist works with issues that specifically affect the mental health and functioning of the family system. Individual sessions may be provided separately to each family member, but for most of the course of treatment, therapy is provided to family members together. This may include children/minors.

Therapy for Minors

Clients who are under the age of 18, and their parents or legal guardian, should be made aware that the Virginia state law provides parents the right to examine their child's records. We recognize that as a parent, you may be concerned about your child and may want to know the extent of conversation during their session. Privacy in therapy is crucial to successful progress. To maintain a level of privacy for your child we ask that parents trust the therapist's discretion in what information is discussed regarding their treatment. However, if your child is engaging in self-harm or is a threat to themselves or others, the therapists will report it to you after discussing it first with your child. It must be noted that your child's therapist is a mandated reporter. That means if your child discloses any type of abuse/or neglect, the therapist is required by law to report it. More information on mandated reporting can be found in the confidentiality section of this agreement.

Extended or Intensive Session

Extended sessions are for individuals, couples, and families who require more than the standard 50–90-minute session, in order to achieve therapeutic goals. An extended session may be a good fit for those with a limited or unique schedule (ex. jobs requiring frequent travel, military deployment) who are unable to attend consistent weekly or biweekly appointments.

Intensive sessions (sessions lasting 4 hours or longer) are designed primarily for couples (pre-marital or marital) who are in acute crisis and are looking for more immediate relief (ex. recent infidelity, relationship trauma). In addition, intensive sessions are ideal for couples whose schedules do not allow for weekly or biweekly sessions or are traveling from another city within the state of Virginia. Intensive sessions for individuals and families are provided on a case-by-case basis and can be discussed with your therapist at time of scheduling.

THERAPIST LICENSURE AND TRAINING

Your therapist Rebecca Jones is a Licensed Professional Counselor (LPC) in the Commonwealth of Virginia (License Number: 0701009918). She earned a Master's in Clinical Mental Health Counseling in 2018 from Auburn University and a Bachelor of Science degree in Psychology from James Madison University in 2016. She is an EMDRIA approved EMDR therapist, as well as a couples specialist trained in Emotionally Focused Therapy. She specializes in treating individuals and couples with a history of developmental trauma and/or acute PTSD.

As an outdoor enthusiast and animal lover, Rebecca believes strongly in the power of providing healing in alternative treatment settings. She completed a post-masters certificate program in Equine-Assisted Mental Health at University of Denver's Institute for Human-Animal Connection in 2019 and is trained to provide EquiLateral Equine-Assisted EMDR.

THERAPY SETTINGS

At Passionately Living, LLC., we believe that therapy can take place successfully both inside and outside of a traditional office. We offer the following therapy settings:

Traditional Indoor Office Setting

The indoor office setting is the most typical place that people receive psychotherapy. The therapy session is conducted sitting down together with your therapist in a therapy office.

Telehealth Setting

When receiving psychotherapy via telehealth, the therapy session takes place via a computer on a secure and confidential healthcare platform. Please note that you will still need to be a resident of Virginia to receive telehealth, even if this setting offers the flexibility to receive therapy while you are in your home or in another location.

Outdoor/Walk-and-Talk Setting

In an outdoor “walk-and-talk” setting, your therapy session takes place outside and usually involves walking together with your therapist. This can take place on the beach or otherwise in nature.

Outdoor with Equine Interactions

Interacting with horses during psychotherapy means that your therapy takes place in a natural and experiential setting. This typically involves a combination of moving around, interacting with horses, and sitting down, all together with your therapist.

You and your therapist will decide together which therapy setting is right for you. At the end of this service agreement, there are consent documents for the outdoor therapy settings. Providing consent for treatment in various settings allows you the flexibility to choose what setting fits your needs most at different times during the course of treatment.

WHAT TO EXPECT AT THE BEGINNING OF THERAPY

Unless the therapist recommended an extended or intensive session, your first appointment consists of a standard intake evaluation (50 or 90 minutes). During this appointment, your therapist will want to learn what led to you making a therapy appointment, the goals you are looking to achieve, and general information about yourself and your current life situation. By the end of this first appointment, you will be provided with some initial recommendations on what your therapist believes will be helpful and you will be able to discuss this together. During this initial stage, you should make your own assessment about your comfort in working with your therapist.

If your therapist determines another therapist would better assist you, they will provide you with names of therapists in your area. After the initial session, your therapist will collaborate with you on a treatment plan that incorporates strategies to help address the challenges you are currently experiencing.

CONFIDENTIALITY

The session content and all relevant materials to your treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such privilege of confidentiality exist and are itemized below:

1. If you threaten or attempt to commit suicide or otherwise conduct yourself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If you threaten grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that you or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly or dependent subject who may be subjected to these abuses.
5. Suspected neglect or exploitation of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If you are being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally we may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If you and your therapist see each other accidentally outside of the therapy office, your therapist will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge your therapist first, they will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. By adding your signature, you are eSigning this form Guardian Signature for Minor

CONTACTING YOUR THERAPIST

Your therapist, Rebecca Jones, schedules her appointments strictly by phone. She can be reached at (757) 514-1655 or (757) 644-1749. Rebecca does her best to answer or return calls within 24 hours on business days. Please be mindful that your therapist is not expected to accept or return calls on weekends. If you believe you may require services during this time, please speak with your therapist in advance and special accommodations may be discussed. If you are in distress, you may attempt to reach your therapist after hours. However, your therapist does not provide 24-hour crisis management and may not be available to return your call. If you are in crisis, please go to the nearest emergency room or call 911. Please do not contact your therapist by email, fax, or the patient portal in crisis, as these are not frequently monitored.

If you are calling your therapist to cancel and/or reschedule an appointment, please leave a voicemail at (757) 514-1655 or (757) 644-1749. It is important that you cancel your appointment at least 24 hours prior to it taking place. Cancellations or missed appointments (no-shows) without a 24-hour notice will be subject to full fee charge. The credit card on file in your patient portal will be charged for this.

If your therapist is going to be unavailable for an extended period of time (one week or longer), you will be notified in advance. If your therapist must cancel or reschedule your appointment due to an unexpected illness or emergency, they will contact you via phone or email to ensure you receive the message.

Text and Email HIPAA Consent

To use text messaging and emails for communications, HIPAA regulations require consent to this in writing. By signing below, you consent to using text and/or email messaging with the full understanding that we cannot guarantee your confidentiality.

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FEES FOR SERVICES

The fees for individual, couples, or family therapy are \$150 for a 50-minute session and \$270 for a 90-minute session. Any additional time with your therapist outside of a

scheduled session or scheduled session length is billed at \$3 per minute. This excludes calls with your therapist for canceling, scheduling and/or rescheduling an appointment. Please note, if you wish to schedule your session on a Saturday or Sunday, an additional fee of \$100 will apply.

The fee for an extended session (180-240 minutes) is charged at a rate of \$3 per minute. The length for your extended session will be agreed upon between therapist and client(s) at time of scheduling. The fee for a half-day intensive (4 hours) is \$720. The fee for a full-day intensive (8 hours) is \$1,440. Your \$150 deposit paid at the time of scheduling will be deducted from the total session fee.

The rate for court appearances (including travel to and from court), documentation required for a court appearance due to subpoena, and any documentation requested by a client outside of regular progress notes will be billed at a rate of \$3 per minute.

Please note that rates may be subject to change during your time in treatment. If there is a change in your current rate, you will be notified prior to your next scheduled appointment.

Cancellations and No-Show Charges

You will be charged in full for your scheduled session when you cancel your appointment with less than 24-hour notice. You will be charged for your session in full if you do not show up to your appointment as scheduled (no-show). The credit card on file in your patient portal will be used for this charge. You will not be charged if you contact your therapist via phone at least 24 hours in advance of your session to cancel or reschedule.

If you fail to cancel your extended or intensive session with less than 24-hour notice or if you no-show, you will be charged for the **ENTIRE** session. Your \$150 deposit paid at the time of scheduling will be deducted from the session fee.

BILLING AND PAYMENT

We accept cash, check, HSA, and major credit cards. Payment is expected at the start of each appointment. The card on file in your patient portal will be charged at the start of each session unless you notify us in advance that another method of payment is preferred.

If you are using an HSA card for payment, we require that a second payment card is kept on file.

If there is an outstanding balance on your account, Passionately Living, LLC., reserves the right to cancel upcoming appointments until payment has been received. We will make every attempt to develop a payment plan with any client struggling to pay a past due balance prior to sending the unpaid invoice(s) to collections.

Please note that we do not accept insurance. We do not directly bill any insurance or medical plan. Please notify your therapist if you need documentation to initiate a reimbursement process through your own insurance company, you must do this at the beginning of your treatment process. Please let your therapist know at your first session. Please note that we cannot guarantee that your insurance company will provide you with reimbursement. It is important for you to know that insurance reimbursement will require you receiving a diagnosis from your therapist.

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NOTICE OF PRIVACY PRACTICES

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

1. Your health information

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights to the health information we keep about you, and describes certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.

- Give you this notice of our legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- The terms of this Notice may change, and such changes will apply to all information we have about you. The new Notice will be available upon request.

2. How we may use and disclose health information about you

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what it means and provide some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

3. Certain uses and disclosures require your authorization

Psychotherapy Notes. We keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

- For our use in treating you.
- For our use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
- For our use in defending ourselves in legal proceedings instituted by you.
- For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. Required by law and the use or disclosure is limited to the requirements of such law.
- Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
- Required by a coroner who is performing duties authorized by law.
- Required to help avert a serious threat to the health and safety of others.

Marketing Purposes. We will not use or disclose your PHI for marketing purposes.

Sale of PHI. We will not sell your PHI in the regular course of our business.

4. Certain uses and disclosures do not require your authorization

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

- When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
- For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
- For health oversight activities, including audits and investigations.
- For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
- For law enforcement purposes, including reporting crimes occurring on my premises.
- To coroners or medical examiners, when such individuals are performing duties authorized by law.
- For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
- Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States;

conducting intelligence or counter- intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

- For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
- For appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with us. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

5. Certain uses and disclosures require you to have the opportunity to object

Disclosures to family, friends, or others.

- We may provide your PHI to a family member, friend, or other person *that you indicate is involved in your care* or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

6. You have the following rights with respect to your PHI

The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if I believe it would affect your health care.

The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.

The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable fee for doing so.

The Right to Get a List of the Disclosures We Have Made to You. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided us with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost-based fee for each additional request.

The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say “no” to your request, but we will tell you why in writing within 60 days of receiving your request.

The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

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SAFETY POLICY

In order to ensure the safety of you and Passionately Living, LLC., employees we ask that you please refrain from bringing any weapons (i.e., guns, knives, harmful objects), drugs, and/or alcohol onto our property and/or with you during outdoor therapy sessions. If you have a concealed carry permit, we kindly ask that you leave your firearm in your vehicle during your visit. We reserve the right to cancel, terminate the therapy session, and/or end the therapeutic relationship at any time it is determined this policy has been violated. You will still be charged for your session in full.

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on any social networking platforms or websites. We do not accept friend or contact requests from current or former clients, nor will we respond to messages. This includes Twitter, Instagram, Facebook, LinkedIn, etc. We appreciate your understanding of this policy.

Passionately Living, LLC. has a public Instagram and Facebook account (Instagram: @whatwouldmytherapistsay & Facebook: Passionately Living LLC). Please note that content shared on these platforms is strictly for educational and entertainment purposes only. If you are a current client, please know that information about scheduling, services provided, and/or treatment will not be provided via social media.

PROFESSIONAL RECORDS

Both law and the standards of our profession require that we keep appropriate records. If we receive a request for information about you, you must authorize in writing that you agree that the requested information be released. If you would like for your therapist to coordinate with other providers to ensure continuity of treatment you may request this at any time and appropriate forms will be made available to you within the client portal. Please understand there may be a reasonable fee for record requests.

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QUESTIONS AND CONCERNS

If you have any questions or concerns about your treatment or billing statement, please talk to us about it. If for any reason you are not happy with the treatment and/or services being provided, please speak directly with your therapist. We welcome your feedback to ensure quality of care.

CONSENT FOR SERVICES AND SIGNATURE DOCUMENTS

Your signature indicates that you have read this Service Agreement and agree to receive psychotherapy services from your therapist Rebecca Jones, LPC, NCC. Your signature below indicates that you are making an informed choice to consent to receiving the services provided by Rebecca Jones, LPC, NCC through Passionately Living, LLC and understand and accept the terms of this agreement.

I have read and agreed to the terms in the outpatient services contract.

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CONSENT FOR OUTDOOR/WALK-AND-TALK THERAPY

I give consent to receive psychotherapy outside of the office, offered through Passionately Living, LLC.

I recognize that complete confidentiality cannot be maintained in this setting, and I accept the possibility that other people may hear parts of my conversation.

I recognize that it is up to the discretion of my therapist whether Outdoor/Walk-and-Talk therapy can be utilized during my sessions.

I hereby affirm that I am in good physical condition and do not suffer from any known disability or condition which would prevent or limit my participation in this setting. I acknowledge that my enrollment and subsequent participation is purely voluntary and in no way required.

I recognize that my therapist and Passionately Living, LLC are not responsible for any accidents, falls, injuries and/or sunburn that may occur during a Outdoor/Walk-and-Talk therapy session.

I recognize that poor weather conditions may keep the session indoors and I will still be committed to attending the full therapy session.

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CONSENT FOR OUTDOOR/EQUINE INTERACTIONS IN THERAPY

I give consent to receive psychotherapy outside of the office, offered through Passionately Living, LLC.

I recognize that complete confidentiality cannot be maintained in this setting, and I accept the possibility that other people may hear parts of my conversation.

I recognize that it is up to the discretion of my therapist whether equine interactions and the general outdoor setting can be utilized during my sessions.

I hereby affirm that I am in good physical condition and do not suffer from any known disability or condition which would prevent or limit my participation in this setting. I acknowledge that my enrollment and subsequent participation is purely voluntary and in no way required.

I recognize that my therapist and Passionately Living, LLC are not responsible for any accidents, falls, injuries and/or sunburn that may occur during a Outdoor/Equine Interactions therapy session.

I recognize that poor weather conditions may keep the session indoors and I will still be committed to attending the full therapy session.

I agree to sign a specific Release, Waiver, and Indemnity Agreement to receive services with equine interactions. This waiver concerns Passionately Living, LLC and the organization where equine interactions takes place, Untamed Spirit Educational and Therapeutic Program.

I agree to follow the directions provided by the therapist for my behavior around horses, my behavior in the equine and farm setting, and use of protective equipment.

Notice of Intrinsic Dangers of Equine Activities pursuant to Code of Virginia 3.1-796.130c: "Intrinsic dangers of equine activities" means those dangers or conditions

that are an integral part of equine activities, including but not limited to, (i) the propensity of equines to behave in ways that may result in injury, harm, or death to persons on or around them; (ii) the unpredictability of an equine's reaction to such things as sounds, sudden movement, and unfamiliar objects, persons, or other animals; (iii) certain hazards such as surface and subsurface conditions; (iv) collisions with other animals or objects; and (v) the potential of a participant acting in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the equine or not acting within the participant's ability.

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RELEASE WAIVER & INDEMNITY AGREEMENT FOR INTERACTIONS WITH HORSES

The undersigned (hereinafter referred to as "Client"), being of legal age or signing in conjunction with a parent, legal guardian, or caretaker if not of legal age, desires to enter upon the premises known as Forward Motion Farm and home to Untamed Spirit Therapeutic and Educational Program and/or to use horses and/or facilities either owned or controlled by Untamed Spirit Therapeutic and Educational Program, and/or to receive training or instruction from the agents, volunteers or employees of Untamed Spirit Therapeutic and Educational Program, and being fully aware of the risk of injury and dangers inherent in entering upon said premises and/or the riding and handling of horses, hereby elects voluntarily to enter upon said premises and/or to participate in said activities, and does hereby willingly enter into this Release, Waiver, & Indemnity Agreement.

Therefore, in consideration of being permitted to enter upon the premises known as Forward Motion Farm and home to Untamed Spirit Therapeutic and Educational Program and/or receive instruction or assistance from the agents, volunteers or employees of Untamed Spirit Therapeutic and Educational Program, Client knowingly and expressly waives Client's rights to sue Untamed Spirit Therapeutic and Educational Program and/or Les Chevaux, LLC, its officers, volunteers, directors, employees, agents, successors, heirs, and assigns, for any injury, death, loss, or damage caused to Client or to Client's property, and Client agrees to assume all risks inherent in riding or otherwise coming in contact with horse, including without limitation, the risks of injury, death, loss, or damage to Client or to Client's property.

Client acknowledge that Client has been given notice of the risks inherent in and intrinsic dangers of equine activities, including (i) the propensity of an equine to behave in dangerous ways which may result in injury, harm, or death to persons on or around them; (ii) the unpredictability of an equine's reaction to such things as sounds, sudden movement, unfamiliar objects, persons, or other animals; (iii) certain hazards such as surface and subsurface conditions; (iv) collisions with other animals or objects; and (v) the potential of a Client acting in a negligent manner that may contribute to injury to the Client or others such as failing to maintain control over the equine or not acting within the Client's ability, and Client expressly agrees to assume all such risks and waives all rights to sue for injuries caused by such risks. This waiver and express assumption of risks shall specifically apply to Client and to any and all minor children and/or wards of Client, in accordance with the terms of Va. Code Ann. §3.1-796.132B, and shall be construed to comply with all exculpatory terms of the Virginia Equine Activity Liability Act, Va. Code Ann. §§3.1-796.130 et seq. (Chapter 27.5, Code of Va. (1950).

If Client is a minor or otherwise under a legal disability, this agreement shall be signed by Client's parent, legal guardian or caretaker. By signing, the parent, legal guardian or caretaker agrees (i) to waive the parent's, legal guardian's, caretaker's and Client's rights to sue the parties named in the immediately preceding paragraph; (ii) to assume, on behalf of the parent, guardian, and Client, the risks set forth in the immediately preceding paragraph, in addition to all other risks of riding or otherwise coming into contact with horses; and (iii) to indemnify and hold harmless Untamed Spirit Therapeutic and Educational Program and/or Les Chevaux, LLC, its officers, directors, volunteers, employees, agents, successors, heirs, and assigns from any loss, claim, suit, or judgment resulting from any injury, death, loss, or damage sustained or claimed by Client (or Client's personal representative), and further to indemnify Untamed Spirit Therapeutic and Educational Program and/or Les Chevaux, LLC, its officers, directors, volunteers, employees, agents, successors, heirs, and assigns from any and all costs of defending such claims, including attorney's fees.

It is expressly agreed by Client and any parent or guardian whose signature appears on this document 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, and that Untamed Spirit Therapeutic and Educational Program and/or Les Chevaux, LLC, its officers, directors, volunteers, employees, agents, successors, heirs, and assigns are covered by the provisions of that 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. Client has been advised to wear protective headgear, and hard-soled, heeled footwear at all times while riding or otherwise coming in contact with horses, and expressly assumes the risk of injury resulting from failure to do so and/or from selecting headgear or footwear which does not adequately protect against injury. I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. By adding your signature, you are eSigning this form Guardian Signature for Minor