The Equine Healing Collaborative
Group Intake Packet

Hello and welcome to The Equine Healing Collaborative! We are happy to have you join our therapy group 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.

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

You will be asked to sign copies and bring them to your first session. 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:_____

Group Name: _____Start Date:_____

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 and horseman 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 property 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.

SESSIONS

Sessions will ordinarily be 90-120 minutes in duration, once per week, over the course of 8 weeks at a time determined by the lead clinician. The time scheduled for your session is assigned to all the members in your group. If you are unable to attend a session, a make-up session will not be available due to the nature of the group setting. We ask that you notify the lead clinician a minimum of 2 hours prior to the scheduled session if you are unable to attend so there is no delay in running the group for the participants who are present. In addition, you are responsible for coming to your session on time; if you are late, your session will still need to end on time. For ongoing open group sessions, notification of participation is not required after your first session. Hours and days of groups may change depending on the need.

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, however you will not be turned away based on your ability to pay. 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.

GROUP CONFIDENTIALITY

You have the right to confidentiality and privacy by the group leaders and other group members. Confidentiality within the group setting is a shared responsibility of all members and leaders. While group leaders may not disclose any client communications or information except as provided by law, group members' communications are not protected. As such, confidentiality within the group setting is often based on mutual trust and respect.

As a member of this group, I agree to not disclose to anyone outside the group any information that may help to identify another group member. This includes, but is not limited to, names, physical descriptions, biological information, and specifics to the content of interactions with other group members.

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 at Natividad Medical Center 831-755-4111 (ask to speak to the crisis team), 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.

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.

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 _____

EHC Payment Options

Here at the Equine Healing Collaborative, we believe in building stronger communities and individuals through the use of Equine Psychotherapy. In order to ensure that no one is ever turned away, we have created a form with payment options so people can participate in treatment without worrying about cost. Please check the box below informing your clinician how you would like to pay.

There are several ways to pay:

⬜ 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.

⬜ 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 / 8 weeks
0.00 to 5000.00	40.00/320.00 total
5000.00 to 6500.00	60.00/480.00 total
6500.00 to 75000.00	70.00/560.00 total
75000.00 to 8500.00	80.00/640.00 total
8500.00 to 9500.00	90.00/720.00 total
95000.00 and above	100.00/800.00
Open Groups	Cost based on that groups rate

Insurance Information

Primary Insurance Name: _____

Member ID: _____

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 _____

Note: For cash pay clients, your credit card will be charged the agreed upon amount after each group 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.

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Client Information

Name:_____

Date of Birth:_____Gender:_____ Pronouns:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Emergency Contact:_____

Emergency Contact Phone Number:_____

Preferred Email Address :_____

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

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

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.

_____ (Date)_____
EHC Clinician

Printed Name_____

Signature_____ (Date)_____

Guardian Printed Name_____

Guardian Signature_____ (Date)_____

The Equine Healing Collaborative Release of Liability

In exchange for participation in the activity of Mindful EAP organized by The Equine Healing Collaborative LLC and/or use of the property at Flying Pig Ranch (10101 Equestrian Place, Salinas, CA 93907), Chez Serdip (3400 Bean Creek Road Scotts Valley,CA 95066), Monterey Bay Horsemanship & Therapeutic Center/Monterey Bay Academy (783 San Andreas Road, Watsonville, CA 95076), South San Jose Ranch (1011 Metcalf Road San Jose, CA 95138), The Rita Dunn Healing Center (350 San Benancio Road, Salinas, CA 93908), and Bella Tierra Ranch (902 Monterey Salinas Highway, Salinas, CA 93908, 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, Monterey Bay Horsemanship & Therapeutic Center/Monterey Bay Academy, Bella Tierra Ranch, 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, Monterey Bay Horsemanship & Therapeutic Center/Monterey Bay Academy, Flying Pig Ranch,Chez Serendip, South San Jose Ranch Ranch, The Rita Dunn Healing Center and Bella Tierra Ranch 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, Monterey Bay Horsemanship & Therapeutic Center/Monterey Bay Academy, Flying Pig Ranch, and Bella Tierra Ranch.

Fees. I agree to pay for all damages to the facilities of The Equine Healing Collaborative LLC, Monterey Bay Horsemanship & Therapeutic Center/Monterey Bay Academy, Bella Tierra Ranch, Chez Serendip, South San Jose Ranch and Flying Pig Ranch property caused by any negligent, reckless, or willful actions by me or my family.

Consent. I, _____ (name) consent to the participation of myself and/or my child _____(child's name) in the activitiest of The Equine Healing Collaborative LLC and agree on behalf of the minor to all of the terms and conditions 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 date shown below 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.

_____	_____	_____
Name of Client	Signature of Client	Date
_____	_____	_____
If client is under 18: Name of Guardian	Signature of Guardian	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

Please Initial below

Instructions For Your First Group 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: P.O. Box 1087, Monterey, CA 93942

- Rita Dunn Healing Center (main site): 350 San Benancio Road, Salinas CA 93908
  Turn left into the property.

- Monterey Bay Horsemanship & Therapeutic Center/Monterey Bay Academy (La Selva Beach): 783 San Andreas Road, Watsonville, CA 95076.
  Please note that this is a shared space. You will check in at the guard area when you arrive. Tell them you are with the Equine Healing Collaborative. You will turn left at the sign for Monterey Bay Riding Academy, turn right when that driveway ends, and park to the left in the parking area. Please wait there for your therapist to greet you.

- Scotts Valley: 3400 Bean Creek Road Scotts Valley,CA 95066
  Park in the parking lot and your therapist will greet you.

- South San Jose Ranch: 1011 Metcalf Road San Jose, CA 95138
  Park on the side of the road and your therapist will meet you at the gate.

- 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.

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- Yorba Linda: 6122 Ridge Way, Yorba Linda CA 92866
  Park in the parking lot/driveway and your therapist will greet you.

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