ASPEN ACHIEVEMENT ACADEMY

A division of

Aspen Education Group

SUPPLEMENTAL DOCUMENTS

for admission

Please note: The initial application needs to be completed & submitted on line at www.aspenacademy.com

Please complete these supplemental documents in addition to the application and fax to 435.836.2477

If you have questions contact your admissions counselor at 435.836.2472

ASPEN ACHIEVEMENT ACADEMY

PO Box 400 / 98 South Main Street

Loa, UT 84747

800.283.8334 Admissions Office

435.836.2472 Main Office 435.836.2477 FAX

www.aspenacademy.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is a RELEASE OF INFORMATION FORM. Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with State and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____

Persons/Organizations authorized to *use or disclose* the information: 1 Aspen Achievement Academy

Persons/Organizations authorized to *receive* the information: Aspen Achievement Academy

Name/Title: _____

Address: _____

City: _____

State: _____ Zip: _____

E-mail address:_____

Phone (___)_____

Name/Title: _____

Address: _____

City: _____

State: _____ Zip: _____

E-mail address:_____

Phone (___)_____

Purpose of requested use or disclosure: 2 _____

This Authorization applies to the following information (select *only one* of the following):3

☐ All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: _____

☐ Only the following records or types of health information (including any dates):

_____

EXPIRATION

This Authorization expires [insert date or event]:4_____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:98 S. Main street, Loa Utah 84747
My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.5

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. 6

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIP AA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: 7 _____

_____

Witness: _____
(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)

_____

1 If the Authorization is being requested by the entity holding the information, this entity is the Requestor.
2 The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
3 This form may not be used to release both psychotherapy notes and other types of health information (*see* 45 *CFR* § *164.508(b)(3)(ii)).* If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.
4 If authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement "end of research study," "none" or similar language is sufficient.
5 Under HIP AA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see* 45 *CFR* § *164.508(d)(1), (e)(2)).*
6 If any of the exceptions to this statement, as recognized by HIP AA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.
7 The requestor is to complete this section of the form.

Aspen Achievement Academy

ASSIGNMENT OF INSURANCE BENEFITS/PHARMACY CLINIC FORM

PATIENT NAME: _____ ADMIT DATE: _____

INSURANCE COMPANY _____

ADDRESS OF INSURANCE COMPANY _____

_____

TELEPHONE NUMBER OF INSURANCE COMPANY _____

GROUP # _____ POLICY _____

INSURED NAME _____ INSURED SS# _____

INSURED EMPLOYER _____

For the purpose of paying all or part of monies owing to ASPEN EDUCATION GROUP for services it has or will render to the above patient, the undersigned hereby irrevocably assigns to ASPEN EDUCATION GROUP any benefit payments payable for the benefit of said patient by the above insurance company or companies and all rights and interest in said policy but only to the extent necessary to pay ASPEN EDUCATION GROUP in full. Undersigned hereby grants to ASPEN EDUCATION GROUP the right to bill the above insurance company at retail or at the contract rate. Undersigned acknowledges and agrees, however, that ASPEN EDUCATION GROUP is not obligated or required to bill the insurance company, and may choose to bill the undersigned directly notwithstanding any insurance coverage that may exist. Undersigned agrees to remain liable to pay the full amount of all monies billed by ASPEN EDUCATION GROUP as a result of rendering services to the above mentioned patient and undersigned's liability will only be reduced by the amount of benefit payments received by ASPEN EDUCATION GROUP from the above referenced insurer. Notwithstanding the above, undersigned's liability will not be reduced until ASPEN EDUCATION GROUP has collected its full retail or contract rate. Undersigned understands that the nature of patient's disability may be such that no benefit payments will be payable under the policy specified above. ASPEN EDUCATION GROUP verifies insurance as a courtesy to the undersigned, and is not responsible for any misinformation received from the insurance company regarding benefits. It is the responsibility of the insured to understand his/her benefits and allowable coverage under the policy. ASPEN EDUCATION GROUP may bill the insurance company as a courtesy only. To the extent necessary to determine liability for payment and to obtain reimbursement, the undersigned authorizes ASPEN EDUCATION GROUP to disclose information from the treatment received to persons or corporations that may be liable for all or any portion of the facility's charges, including but not limited to insurance companies, health plans and Workers' Compensation carriers. Such information may include psychiatric evaluations, diagnoses, history and physical examination reports, program notes, physicians' orders and laboratory results, as well as school information. Such records may contain psychiatric or substance abuse information. Any monies owing by the undersigned under the terms of this Agreement shall be paid in full within thirty (30) days after billing by ASPEN EDUCATION GROUP unless other arrangements have been made. In the event that collection efforts are undertaken by ASPEN EDUCATION GROUP to enforce any of the terms of this Agreement, all expenses associated therewith, including attorneys' fees, will be paid by the undersigned. The undersigned acknowledges that he or she is entitled to receive a copy of this assignment/authorization.

We will do our best to process the prescription and medical expenses under your insurance, but please understand that some insurance companies do not contract with all pharmacies and doctors/clinics. **Therefore we require that you submit a credit card number to cover any expenses that may incur for medical reasons.** You will remain fully liable for any amounts not paid by your insurance. **Input credit card information on the Exhibit A, Page R**

_____ _____

Parents Signature Date

Please attach an enlarged photocopy of the student's medical insurance card in case of necessity.

Dear Parents,

We hope the following information will guide you as you prepare to send your student to our program.

Medications –

(1) Make sure that you fill out the medications section of the application COMPLETELY with the students' current medications. Please list it as it appears on the packaging: medication name, dosage, and administration time. PLEASE SEND ENOUGH MEDICATIONS FOR THE ENTIRE LENGTH OF THE PROGRAM. If you are unable to do this, plan on sending us a refill as soon as your insurance allows. Our nurse will contact you 1-2 weeks before your child runs out of medication.

(2) We must administer medications as written on the prescription bottle; if the label is incorrect we need a new written prescription from the prescribing physician.

(3) Do **not** send over the counter medications. We will provide meds such as benadryl, tylenol, ibuprofen as needed.

(4) We **do not accept herbal medications and supplements.** Students are given a multi-vitamin daily. **Do not send** prescription pain medication, benzodiazepines (such as Xanax, lorazepam, diazepam), or prescription acne medication that have a high sensitivity to the sun.

(5) If your child requires an inhaler, please send at least (2) two and the label should be on the inhaler itself, not on the box.

(6) If your child needs to have Epi-pens available for allergic reactions, please send two (2) in their prescription boxes.

(7) Please check the expiration date on all prescriptions. We are not allowed by law to administer expired medication.

(8) **We do not accept** sample medications unless accompanied by a written prescription.

Immunizations:

Please attach a copy of students' current immunization record. If he/she has not had a tetanus immunization within the last 10 yrs, it will be given when they arrive at our program.

Eyewear:

If your child requires corrected vision, **please send glasses** in a protective case. **Contact lenses are not recommended for field wear**. There is just too much dust and wind and contact lenses increase the risk for an eye infection. If contacts are the only possible choice they should be disposable, extended wear and extra contacts, a contact case and solution will need to be included.

Orthodontic and Dental Care:

If your child requires an orthodontic apparatus, such as a retainer, please include the case to keep it in when not in use. Please get any dental problems taken care of before your student is admitted to our program.

Aspen Achievement Academy
Over The Counter Medications

We have the following over the counter medications available for your child while he/she is a student in our program. We need your permission in order to administer these medications if they are needed.

Student Name:_____

PLEASE MARK YES OR NO ON THE FOLLOWING MEDICATIONS

Medication	Yes	No
Cold Medications – Advil, Contac, or Tylenol cold	_____	_____
Benadryl or Claritin for allergy symptoms	_____	_____
Daily Multiple Vitamins	_____	_____
Ibuprofen for minor aches & pain	_____	_____
Imodium for diarrhea	_____	_____
Pepto-bismal, rolaids, tums or alka-seltzer for upset stomach	_____	_____
Antibiotic ointment or hydrocortisone cream for minor skin irritations	_____	_____
Anti-fungal cream for athlete's foot	_____	_____
Epinephrine (Epi-Kit) for severe allergic reaction or severe asthma attack	_____	_____

Additionally, my child _____takes the prescription medications outlined in section 16 of submitted application. I hereby authorize Aspen Achievement Academy to oversee self-administration of those prescription medications.

_____ _____
(Parents Name Printed) (Date)

_____
(Parents Signature)

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT, that I/we _____ (the parent(s)/legal guardian(s) and hereafter known as the "Sponsor"), do hereby certify to Aspen Education Group, which owns and operates the program known as Aspen Achievement Academy , that I/we are the true and lawful attorney in-fact and legal custodian(s) for _____, (hereinafter the "Student"), and said student is my/our _____. Student was born on _____. We hereby execute this Power of Attorney for the purpose of providing custodial care, educational, therapeutic and clinical services in connection with the Aspen Achievement Academy (hereinafter known as the "Program").

Without limiting or qualifying the general Power of Attorney granted and delegated by Sponsor to Aspen in the paragraph above, Sponsor specifically grants to Aspen the following powers:

1. To provide or obtain all medical, dental, psychiatric treatment and hospital care, and to authorize a physician to perform any and all procedures that may appear to be medically necessary for the well being of the Student;

2. To guide and discipline the Student as deemed necessary and reasonable by Aspen (but not to include physical punishment);

3. To physically restrain the Student should he/she become a danger to himself/herself or to anyone else, as deemed necessary by Aspen;

4. To allow the Student to participate in all activities that may risk physical injury or illness, as outlined in Aspen's Enrollment Agreement and Program Description, and

5. To search the person and personal effects of the Student at any time as Aspen Education Group in its discretion deems appropriate, and seize and confiscate any items deemed by Aspen to be contraband or counterproductive to the Student's successful completion of the Program. The search of the Student's person may require Student to remove all of his or her clothing and may include a "strip search" of all or any portions of Student's body, including cavities in which contraband could be hidden.

6. To restrict the Student's access to telephone calls, visitors and delivered materials.

This Power of Attorney shall be effective from date of arrival, beginning _____, 20 ____ and ending upon the Student's completion of the Program, unless terminated by Sponsor by withdrawing the Student from the Program prior thereto.

I/We have executed this Power of Attorney on this _____day of _____, 20____.

I/We declare under penalty of perjury that the foregoing is true and correct.

_____	_____
Signature of Sponsor (Father/Guardian)	Signature of Sponsor (Mother/Guardian)
_____	_____
Home Address	Home Address
_____	_____
Date of Birth	Date of Birth
_____	_____
Driver's License Number	Driver's License Number
_____	_____
Notarized by	Date

CONTINUUM OF CARE AGREEMENT

In order to ensure optimum success of the program, it is necessary that families be involved in the processes of learning, writing, communicating and counseling. We require that families commit to the following activities while the student is in our program:

1. Receive counseling from local therapist. Please provide the name, address and telephone number of local therapist below, so your Aspen therapist can coordinate treatment with him/her

2. Complete parent education assignments

3. Complete the Family Assessment as directed before the second week, and participate in a Family Assessment review with an Aspen therapist and your home therapist where available.

4. Be available for weekly teleconference with Aspen's therapist and/or staff

5. Participate in the 3-day graduation workshop held at the end of the program

6. Continue family counseling and/or attendance in community-based support groups following completion of the Aspen program.

7. Listen to the 'Family IQ' 4 CD series and complete parenting workbook.

8. Attendance for our on-line meeting presentations. Adobe Connect is an online space where we at Aspen can present information about our program, relationship patterns, communication skills, adolescent development and other pertinent topics. You will be both online at your computer and on a telephone conference call with the Aspen presenter and other parents so that you can see and hear the presentation. Courses are typically offered weeknights from 6:00 to 7:30 MST. You will receive an invitation to participate.

Commitment to the above responsibilities is necessary for successful family reintegration after student completes the Aspen program.

HOME THERAPIST INFORMATION:

Name:_____

Address: _____

Phone: _____

E-mail address: _____

* *

By signing this form, the parent/guardian commits to the foregoing, and grants a release of information allowing Aspen staff to communicate with therapist identified above.

Father:_____ Date: _____

Mother: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

OF

ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES

Effective Date: April 14, 2003

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.

If you have any questions about this notice, please contact RUTH MOORE

WHO MUST FOLLOW THE REQUIREMENTS OF THIS NOTICE?
Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Aspen Education Group and its affiliated entities (collectively, "Aspen") must take steps to protect the privacy of your "protected health information" (referred to in this Notice as "PHI" or "health information"). PHI includes information that we have created or received regarding your health or payment for your health. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

Aspen Education Group is an organization that is committed to improving the quality of life for youth and their families. Aspen operates 48 programs in nine states that provide innovative quality educational programs that promote academic and personal growth. The services provided by Aspen's programs are diverse and, in some cases, the provision of health care treatment and services may be the primary function – for example, the provision of mental health services by Aspen Community Services – or, in other cases, the provision of health care treatment may be a secondary or ancillary function -- for example, a nurse's office located on an Aspen school campus. Aspen also operates an employee benefit health plan for the benefit of its employees.

All of these programs, functions and services operated or provided by Aspen are conducted through separate but affiliated entities which are identified on Exhibit A attached to this Notice. Under the privacy standards contained in HIPAA, legally separate but affiliated entities may designate themselves as a single covered entity for compliance purposes. Accordingly, this Notice constitutes notice of the privacy practices for all of the Aspen-affiliated entities, sites and locations that are listed on the attached Exhibit A, which will follow the terms of this Notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment or health care operations purposes as described in this Notice. All Aspen employees are required to maintain the confidentiality of PHI in accordance with this Notice and receive appropriate privacy training.

Please note, however, that this Notice of Privacy Practices does <u>not</u> apply to student medical records that are maintained by Aspen's four special education day schools in Southern California -- Hawthorne Academy, Rossier Park High School and Elementary School, and Leeway School. The reason is that these schools are subject to the Federal Educational Rights and Privacy Act ("FERPA") resulting from their receipt of indirect funding from the U.S. Department of Education. The privacy rights and protections afforded to student medical records maintained by those schools will be governed by FERPA instead.

RESPONSIBILITIES OF ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES
We are required by law to:
Make sure that health information that identifies you is kept private (with certain exceptions);
Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
Follow the terms of this Notice that are currently in effect.

This Notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BY ASPEN THAT DO NOT REQUIRE YOUR AUTHORIZATION
Aspen uses and discloses protected health information in a number of ways connected to the provision of health care treatment and services, payment for care, and our health care operations. Some examples of how we may use or disclose your health information without your authorization are listed below.

We may use or disclose your protected health information without your authorization as follows connected to the provision of health care treatment and services:
To physicians, nurses, and others involved in your health care or preventive health care.
To other health care providers treating you such as hospitals, pharmacies, labs, emergency room staff and specialists. For example, if you are being treated for an injured knee, we may share your health information among your primary physician, the knee specialist, and your physical therapist so they can provide proper care.

We may use or disclose your protected health information without your authorization as follows in relation to payment for care:
To administer your health benefits policy or contract (for Aspen Education Group Employee Benefit Plan members).
To bill you for health care we provide.
To pay others who provided care to you.
To other organizations and providers for payment activities unless disclosure is prohibited by law.

We may use or disclose your protected health information without your authorization as follows in relation to health care operations:
To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we may use your health information to review and improve the quality of care you receive, to provide training, and to evaluate the performance of our staff in caring for you.
To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your health information with other organizations for this purpose, they must agree to protect your privacy.)

We may use or disclose your protected health information without your authorization for legal and/or governmental purposes in the following circumstances:

As required by law -- When we are required to do so by federal, state or local law.

Public health and safety -- To an authorized public health authority or individual for public health and safety purposes, including to:

- Protect or prevent a serious threat to the health and safety of the public or of another person.
- Prevent or control disease, injury, or disability.
- Report vital statistics such as births or deaths.
- Report reactions to medications or problems with products and notify people of recalls of products they may be using. (Food and Drug Administration.)
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notify an employer concerning work-related injuries or illnesses or workplace medical surveillance in situations where the employer has a duty under federal or state law to keep records on or act on such information.

Abuse or neglect -- To the appropriate government authority authorized to receive reports regarding abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law. However, no consent is required in cases involving child abuse or neglect.

Health oversight activities -- To health oversight agencies for certain activities such as audits, investigations, inspections and licensure.

Lawsuits and disputes -- In the course of any legal proceeding, in response to an order of a court or administrative agency. Also, in certain cases, in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law enforcement -- To law enforcement officials in limited circumstances for law enforcement purposes. For example disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.

Military activity and national security – To the military (if you are a member of the armed forces), and to authorized federal officials for national security and intelligence purposes or in connection with providing protective services to the president of the United States.

Workers' compensation – Where authorized by law in order to comply with the workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

We may also use or disclose your protected health information without your authorization in the following miscellaneous circumstances:

Facility directory information -- Unless you object, we may use and disclose your name, the location at which you are receiving care, your general condition (e.g., fair, stable, etc.), and your religious affiliation in our facility directory. All of this information except religious affiliation will be disclosed to people who ask for you by name. Members of the clergy (such as a priest or rabbi) will be told your religious affiliation if they ask (but they don't have to ask for you by name). This is to help your family, friends, and clergy visit you in the facility and generally know how you are doing.

Family and friends – Unless you object, we may disclose health information about you to a family member, relative, a close friend - or any other person you identify who is directly involved in your health care - who is involved in your care or who helps pay for your care. If you are either not present or unable to make a health care decision for yourself and we determine that disclosure is in your best interest, we may also disclose such health information about you to those persons. For example, we may disclose health information to a friend who brings you into an emergency room.

Appointment reminders – To remind you that you have a health care appointment with us. These reminders may be made by postcard, phone, or voicemail unless you specifically ask us to communicate with you through a different method as described later in this Notice.

Treatment alternatives and health-related services -- To communicate with you about treatment services, options, or alternatives, as well as health-related benefits or services that may be of interest to you.

Employer group health plans – For Aspen Education Group Employee Benefit Plan members, we may communicate with your employer for certain administrative activities.

Health insurance underwriting -- For Aspen Education Group Employee Benefit Plan members, we may use your health information for underwriting, premium rating or other health insurance-related activities

Research - For research purposes provided that certain steps are taken to protect your privacy. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the facility

De-identify information -- To "de-identify" information by removing information from your health information that could be used to identify you.

Disaster relief -- To an authorized public or private entity for disaster relief purposes. For example, we might disclose your health information to help notify family members of your location or general condition.

Coroners, funeral directors, and organ donation -- To coroners, funeral directors, and organ donation organizations as authorized by law.

Correctional institution -- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official for certain purposes, such as (1) providing health care to you by the institution; (2) protecting your health and safety or the health and safety of others; or (3) protecting the safety and security of the correctional institution.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BY ASPEN THAT REQUIRE US TO OBTAIN YOUR AUTHORIZATION

Except in the situations listed in the sections above, we will use and disclose your health information only with your written authorization. If you sign an authorization you may revoke it at any time in writing, although this will not affect information that we disclosed before you revoked the authorization. If you would like to ask us to disclose your health information, please contact the Aspen Privacy Officer at (562) 467-5500 for an authorization form. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the right to:

Restrictions on use or disclosure -- Request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Please note that we are not required to agree to your request. If we do agree, we will honor your limits unless it is an emergency situation. To request restrictions, you must make your request in writing to the Aspen Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Confidential Communications – Request that we communicate with you about health matters by another means or at another location. For example, if you want us to communicate with you at a different address we can usually accommodate that request. Any request must be made in writing to the Aspen Privacy Officer. Your request must specify how or where you wish to be contacted. We will agree to reasonable requests.

Inspect and copy -- Inspect and copy health information that may be used to make decisions about your care. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Aspen Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. In certain situations we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.

Amend -- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Aspen. To request an amendment, your request must be made in writing and submitted to the Aspen Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Aspen;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Accounting of disclosures – Request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, (as those functions are described above) and for other exceptions pursuant to the law. To request this list or accounting of disclosures, you must submit your request in writing to the Aspen Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Paper copy -- Request a paper copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

CHANGES TO PRIVACY PRACTICES

Aspen may change the terms of this Notice at any time. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. If we change any of the practices described in this Notice, we will post the revised Notice on enrollee-accessible web sites and at Aspen clinic sites. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Aspen or with the Secretary of the Department of Health and Human Services. To file a complaint with Aspen, write to Ruth Moore, Vice President, Corporate Compliance, at 17777 Center Court Drive, Suite 300, Cerritos, CA 90703. For more information on how to file a written complaint, contact the Aspen Privacy Officer at (562) 467-5500. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

QUESTIONS

If you have any questions about this Notice or would like an additional copy, please contact the contact the Aspen Privacy Officer at (562) 467-5500.

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Aspen Education Group and its affiliated entities. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our Notice, you may request a copy of the revised notice by accessing our web site (http://www.aspeneducation.com) or contacting our organization at (562) 467-5500. If you have any questions about our Notice of Privacy Practices, please contact Aspen's Privacy Officer at (562) 467-5500.

I acknowledge receipt of the Notice of Privacy Practices of Aspen Education Group and its Affiliated Entities.

Signature: _____ Date:_____
(individual/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

[To be completed only if no signature is obtained.] If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Aspen representative: _____ Date: _____

ASPEN ACHIEVEMENT ACADEMY ENROLLMENT AGREEMENT

This agreement ("Agreement") is entered into by and between Aspen Achievement Academy, LLC, a Delaware limited liability company (hereinafter "Aspen"), an outdoor adolescent therapy program, which is described in the program: _____ parent(s) and /or guardian(s) of the Student (hereinafter the "Sponsors"). Sponsor's address is _____and phone is: _____

In consideration of the mutual promises set forth in this Agreement, Aspen and Sponsor (hereinafter the "Parties") mutually agree as follows:

1. SPONSOR'S REPRESENTATIONS. Sponsor warrants that Sponsor is the legal parent(s) and/or guardian(s), having legal custody, of the following child: _____ does hereby contract with Aspen for the Student's enrollment in the Program according to the terms and conditions of this Agreement. In entering into and performing under this Agreement, Aspen is relying on all representations and promises of the Sponsor contained or expressed in this Agreement and all other documents and information sheets from Sponsor to Aspen, and Sponsor expressly warrants the truth and accuracy of the same.

2. ENROLLMENT OF THE STUDENT. Upon Sponsor's initial payment as set forth in Exhibit "A", and completion of this Agreement, the Enrollment Application and all related documentation, and upon Aspen's execution of this Agreement, Aspen shall accept the Student conditionally for enrollment in the Program, subject to the terms and conditions of this Agreement. Sponsor acknowledges and agrees that Aspen's conditional acceptance of the Student is subject to the personal evaluation and screening process conducted by Aspen prior to completion of the Assessment phase of the Program. If the Student satisfies Aspen's screening criteria, Aspen shall accept the Student and, except as otherwise provided herein, permit the Student to complete the Program. If the Student fails to satisfy Aspen's screening criteria, the Student will be returned promptly to Sponsor and Aspen will also return the prepaid tuition fee to the Sponsor, less a $750.00 evaluation/screening fee and a deduction for all reasonable expenses incurred by Aspen on behalf of the Student and/or the Sponsor prior to the Student's return.

3. TERM OF AGREEMENT/CUSTODY. Assuming the Student is accepted into the Program, the term of this Agreement shall be _____ **Days,** with the minimum length of stay being 35 days, beginning with the Student's arrival in Salt Lake City, Provo, or Loa, Utah, as the case may be, now anticipated on _____ (the "Arrival Date"). On the Arrival Date, Sponsor shall transfer, by a Power of Attorney in the form received and executed by Sponsor, temporary custody of the Student to Aspen for the duration of the Agreement, unless either party terminates this Agreement prior thereto by giving written notice to the other party pursuant to the terms of this Agreement herein or until the Student attains the age of eighteen (18), unless the Student (a) has otherwise been placed in the custody of Aspen by a court of proper jurisdiction.

4. PROGRAM COSTS AND PAYMENT TERMS.

A. PROGRAM FEE. The Student is accepted with the expectation that the Student will complete the entire Program. Unless otherwise set forth in Exhibit "A", the Program fee is Four Hundred Sixty Five Dollars and no cents ($465.00) per day, a non-refundable Two Thousand Four Hundred Dollars ($2,400.00) enrollment fee and any optional therapy/professional fees.

B. SCHEDULE AND METHOD OF PAYMENT OF PROGRAM FEES; LATE FEES; EXTENSIONS.

(1) At the time of admission, private pay sponsors shall pay the full initial amount of the student's scheduled stay plus the enrollment fee.

(2) This initial payment may be paid by check. All subsequent payments, if any, shall be paid only by accepted credit card (VISA, MasterCard or American Express), wire transfer or pre-authorized electronic check debit (ACH).

(3) Sponsor shall also provide a valid credit card number with available credit at the time of admission. In the event that any fees, costs or subsequent extensions, including but not limited to medication costs, outfitting costs and additional medical expenses, are not paid when due, Sponsor authorizes the program to charge these items, including late fees, to this credit card number.

(4) With the exception of the discharge summary, student files and records will not be released after a student discharges until all tuition and fees are paid in full.

(5) Students with student loans must provide a copy of an executed promissory note from the lending institution at the time of admission. Actual funding must take place within five days of enrollment.

(6) The program is not in a position to absorb delinquent insurance balances. The program reserves the right to discharge students whose insurance claims become delinquent. Students with a contracted insurance provider must provide the program with pre-approval by the insurer at the time of admission. Sponsor shall pay the enrollment fee, co-pay and deductible at that time. If the contracted insurance provider fails to pay within 60 days of submission of a claim, Sponsor shall pay the amount due. Students with a non-contracted insurance provider must pay the full program cost, including the enrollment fee, at the time of admission. Sponsor will be timely refunded after the program receives insurance payments, if any (excluding AB3632).

(7) Any extension must be agreed upon by staff and sponsor prior to its commencement. Payment for an extension must be paid in advance for the full length of the additional stay. Failure to pay within the first week of the extended period could result in immediate student discharge.

C. EMERGENCY ADMISSION EXCEPTION. Upon written approval by the program, the Sponsor of a student who is admitted within 48 hours of the initial call shall pay a deposit of a minimum of 10 days and sign an enrollment agreement. This deposit must be secured by a third party, such as a credit card, wire transfer, ACH transfer or cashier's check. Personal checks are not acceptable for deposits. Full payment for the program's minimum length of stay must be received no later than seven days of admission. If payment for the remainder of the agreed upon minimum length of stay has not been received within seven days of admission, the student will be discharged prior to 10 days.

D. PAYMENT/CANCELLATION REFUNDS. A cancellation received less than seven (7) days prior to the arrival date will result in a 50% refund. The amount retained by Aspen may, if deemed appropriate by Aspen, be used as credit against any future enrollment of the Student.

E. EARLY WITHDRAWAL OF STUDENT. If Sponsor withdraws Student before expiration of the minimum period of enrollment without the recommendations of the Program Director, Sponsor forfeits the remaining balance of the minimum stay. Any pre-payments above and beyond the minimum stay will be reimbursed to Sponsor.

F. ADDITIONAL COSTS AND EXPENSES. In addition to the Program fee, Sponsor agrees to pay for the following expenses of the Student: transportation from the Student's current residence to Salt Lake City , Provo, or Loa, Utah, as the case may be, and return transportation to the Student's current residence; food and lodging expenses for any holding period before commencement of the Program and/or after completion of the Program; all medical, dental, hospital, and related expenses incurred by or for the Student and all required personal items specified in the Student Clothing/Equipment List. Sponsors are also responsible for any additional escort fees required for transporting Student to and/or from the Program to another location (i.e. airport, doctor's appointment or special event). Sponsors are responsible for the cost of any psychiatric evaluations performed by a psychiatrist or psychological testing performed by a contracted psychologist.

G. PERSONAL INJURY AND DAMAGE TO PROPERTY. Sponsor agrees to accept full responsibility for (1) the repair or replacement of any property damaged, defaced, or destroyed by the Student, whether owned, leased, or controlled by Aspen or any third party, and (2) any personal injury to any Aspen personnel, other students or third parties caused, in whole or in part, by the Student; and to promptly reimburse Aspen for any costs and expenses, including legal fees, it may incur in connection therewith.

H. RUNAWAY EXPENSES. In the event the Student runs away from the Program, Aspen will make every reasonable effort to find the Student and return the Student to the Program or to the Sponsor. An accounting of the expenses incurred by Aspen in finding and returning the Student will be made to the Sponsor who agrees to accept full responsibility for any and all such costs and expenses, and to pay the same within seven (7) days of the Sponsor's receipt of said accounting.

I. LOSS OR DAMAGE TO STUDENT'S PROPERTY. Aspen is not liable for any loss of or damage to any of the Student's property. The Student is fully responsible for the same at all times.

J. SUBCONTRACTING. Sponsor agrees and consents to Aspen's subcontracting certain services to be rendered under this Agreement to persons or entities deemed by Aspen to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both parties. Aspen is not responsible for the services provided by such third-party contractors and is hereby released from any liability arising from such services. All clinicians furnishing services to the Student, including any psychiatrists, psychologists, mental health professionals, or internists or the like, are independent contractors with the client and are not employees of Aspen. The Student is under the care and supervision of his/her attending clinician and it is the responsibility of the Student's clinician to obtain the Sponsor's informed consent, when required, for medical, surgical, or psychiatric treatment, special diagnostic or therapeutic procedures, or other services rendered the Student under the general and special instructions of the clinician.

K. NURSING CARE. Aspen provides only general nursing care unless, upon orders of the Student's physician, the Student is provided more intensive nursing care. If the Student's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the Sponsors. Aspen shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that Student is not provided with such additional care.

5. ASSUMPTION OF RISKS; RELEASES AND INDEMNITIES. Sponsor acknowledges serious hazards and dangers, known and unknown, inherent in the Program, including but not limited to ranch, agricultural and vocational activities, emotional and physical injuries, illness or death that may arise from strenuous hiking, climbing and camping in a natural environment, exposure to the elements, plants and animals, running away from the Program, "acts of God" (nature), the ropes course, kayaking, water sports, stress, involvement with other students, self-inflicted injuries, and transportation to and from the Program's field location(s). Sponsor understands that in participating in the Programs Student will be in locations and using facilities where many hazards exist and is aware of and appreciates the risks which may result. Sponsor understands that accidents occur during such activities due to the negligence of others which may result in death or serious injury. Sponsor and Student are voluntarily participating in the Programs with knowledge of the dangers involved and agree to accept any and all risks.

In consideration for being permitted to participate in the Programs, Sponsor agrees to not sue, to assume all risks and to release, hold harmless and indemnify Aspen and any and all of its predecessors, successors, officers, directors, trustees, insurers, employees, managers, agents, volunteers, community organizations, administrators, heirs, attorneys, executors, assigns and/or related or affiliated business entities including, but not limited to, Aspen Achievement Academy, Aspen Education Group and Aspen Ranch Residential Treatment Center (collectively all of the above persons and entities shall be

referred to as the "Released Parties" hereafter) who, through negligence, carelessness or any other cause, might otherwise be liable to Sponsor or Student under theories of contract or tort law.

Sponsor intends by this Waiver and Release to release, in advance, and to waive his or her rights and discharge each and every one of the Released Parties, from any and all claims for damages for death, personal injury or property damage which Sponsor may have, or which may hereafter accrue as a result of Student's participation in any aspect of the Programs, even though that liability may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective property or equipment owned, maintained or controlled by them or because of their possible liability without fault. Additionally, Sponsor covenants not to sue any of the Released Parties based upon their breach of any duty owed to Sponsor or Student as a result of their participation in any aspect of the Programs. Sponsor understands and agrees that this Waiver and Release is binding on his or her heirs, assigns and legal representatives and that the Released Parties shall be exempt from liability to Sponsor, his or her heirs, assigns and legal representatives.

Student is physically capable of participating in the Programs, and his or her medical care provider has approved his or her participation. If Sponsor is aware that Student is under treatment for any physical infirmity, ailment or illness, Student's medical care provider knows of and has approved Student's participation in the Programs. Sponsor acknowledges that Sponsor, and Sponsor alone, is solely responsible for Student's personal health and safety, and the personal property Student brings with him or her.

Sponsor acknowledges that the medical insurance information Sponsor has provided on the Medical Form is current and complete and that Sponsor is solely responsible for procuring and maintaining all medical insurance Sponsor deems necessary and that the Released Parties have recommended that Sponsor procures and/or maintains medical insurance. Sponsor accepts full responsibility for any costs incurred for medical treatment due to failure to procure or maintain insurance, or providing outdated or falsified insurance information. Sponsor understands that it is ultimately Sponsor's responsibility to provide payment to any hospital/emergency response technicians/emergency transport company that may provide services to Student as a result of injury/illness during the Programs.

Sponsor agrees that this Release extends to all claims of every nature and kind whatsoever, and hereby expressly waives all rights under California Civil Code section 1542 which provides as follows:

> **"A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."**

Sponsor agrees to indemnify the Released Parties from any and all actions, causes of action, claims, demands, damages, costs (including attorneys' fees), expenses, liabilities and charges, known or unknown (the "Liabilities") arising out of or in connection with claims and/or actions relating to or brought by or on behalf of Student, including, without limitation, claims related to or arising out of the Minor's participation in the Program. **Initials: _____.**

6. AUTHORIZATION FOR MEDICAL CARE AND RECORDS. In the event of an accident, injury, illness, or other medical necessity, Sponsor hereby authorizes Aspen to: (a) provide emergency first aid to the Student in the field and en-route to any hospital or clinic, (b) arrange for any medical, dental, psychiatric, hospital, ambulance or other health-related care for the Student deemed necessary by Aspen's staff; and (c) authorize a physician, dentist or other health-care professional(s) to perform any procedure(s) that the health-care professional(s) deems necessary for the well-being of the Student. All costs and expenses incurred for these services shall be the sole responsibility of the Sponsor. Sponsor also authorizes Aspen to arrange for a physical examination (including a drug screen urine/blood test, at Aspen's option) and any psychological assessments of the Student deemed necessary by Aspen prior to the Student's beginning the Program. Sponsor also authorizes any and all medical doctors, psychiatrists, psychologists, counselors, therapists, hospitals, clinics and treatment centers that have treated or counseled the Student, and whose names Sponsor shall provide to Aspen, to release all information regarding the Student's medical and/or psychological history, diagnoses and treatments to Aspen upon request. Aspen shall handle all such protected health information (also "PHI") pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act ("HIPAA") of 1996.

7. AUTHORIZATION FOR SEARCH AND SEIZURE. Sponsor hereby authorizes Aspen personnel to search the person and personal effects of the Student at any time, including a "strip search." In connection with such search, Aspen may, in its discretion, require Student to remove all of his or her clothing and may search Student's entire person, including any body cavities in which contraband may be hidden. Aspen is further authorized to confiscate any and all items deemed by Aspen to be contraband or counterproductive to the Student's successful completion of the Program. The disposition of all items confiscated by Aspen shall be left to the sole discretion of Aspen**.**

8. AUTHORIZATION FOR RESTRAINT. Sponsor hereby authorizes Aspen personnel to physically restrain, control and detain the Student by the exercise of necessary restraints when deemed necessary by Aspen, for purposes including but not limited to escorting the Student to and from the Program's location, returning the Student to the Program if the Student runs away, or preventing the Student from jeopardizing the Student's own safety or the safety of others. In the event of a runaway, all appropriate law enforcement agencies or security personnel of any federal, state, county or municipal entity are hereby directed to detain and retain custody of the Student until Sponsor or any personnel of Aspen arrive, at which time Aspen personnel may re-obtain custody or control of the Student or authorize continued custody by the law enforcement agency until travel is arranged for the Student's return home.

9. RESEARCH AUTHORIZATION. Sponsor hereby authorizes Aspen to use data from the Student's records, tests, and assessments for purposes of ongoing research, provided that the Student's name and identity will be kept confidential and not used in any published materials.

10. EARLY TERMINATION BY ASPEN/LIQUIDATED DAMAGES. Aspen reserves the right to terminate this Agreement at any time due to: (i) failure of Sponsor to pay any amounts due under paragraph 4; (ii) illegal, uncontrollable, or dangerous behavior by the Student; (iii) discovery of any unprompted or previously un-known physical, medical, mental, or emotional problem(s) of the Student; or (iv) for any other reason if Aspen deems it necessary for the protection of the Student, any other student(s) or the integrity of Aspen's Program. **In the event that Aspen elects to terminate the Student pursuant to the terms of this paragraph, Sponsor understands and agrees that Sponsor forfeits all monies pre-paid to the program.** The forfeiture reflects the recognition that certain costs associated with making the program available to the Student are incurred, whether or not the program is completed, including such items as salaries, inventories, and other general operating expenses. Therefore, Sponsor understands and agrees that the policy of non-refundable payments and expenses is a reasonable estimate of the losses (i.e., Liquidated Damages) the program incurs with the early termination of Student.

11. SPONSOR EDUCATION PROGRAM AND COOPERATION. Sponsor agrees to attend the seminar for parents and guardians of the students conducted by Aspen at the end of the Program, and to give Sponsor's full cooperation to Aspen personnel throughout the Program, in order to maximize the benefits of the Program for the Student and the Sponsor. Sponsor also agrees to read any educational materials and watch any video programs sent to Sponsor by Aspen, and to fill out and return to Aspen any interactive educational materials, while the Student is in the Program.

12. ESCORTS. If an escort is required to bring the Student to Utah for the Program, Sponsor agrees that any escort or escort service used by Sponsor, whether or not Sponsor is referred to the escort by Aspen, is in all respects an independent contractor contracting directly with Sponsor. Sponsor agrees that Aspen bears no responsibility of any kind for any such escort service or the negligence or failure thereof.

13. HEALTH INSURANCE. Sponsor warrants that the Student is presently covered, and will for the duration of the Program be covered, by adequate health insurance covering claims that may arise in connection with any accident, injury or illness that the Student may suffer or incur during the Program. Whatever deductibles or coverage exclusions may apply in a given case shall be satisfied entirely by Sponsor.

14. EMANCIPATION. Sponsor warrants that the Student is a minor, both by age and as a matter of law, that the Student does not qualify under the law as an "emancipated minor," and that the laws of the Student's state of residence permit Sponsor to place the Student in the Program without the Student's consent.

15. DELAYED PERFORMANCE. Except for the obligation to make payments when due hereunder, all other obligations under this Agreement shall be suspended for so long as one or both Parties hereto are prevented from performing hereunder by acts of God/nature, the elements, acts of federal, state or local governments, agencies or courts, damage to or destruction or unavoidable shut-down of necessary facilities, or other matters beyond their reasonable control; provided, however, that any party so prevented from complying with its obligations hereunder shall promptly notify the other party thereof and shall exercise due diligence to remove and overcome the cause of such inability to perform as soon as practicable.

16. ATTORNEY'S FEES. In the event that either party is found in default or material breach of any specific promise, term or condition expressly set forth in this Agreement by an arbitrator(s) or a court of competent jurisdiction, said party shall be liable to pay all reasonable attorneys' fee, court costs and other related collection costs and expenses incurred by the other party in enforcing its contractual rights hereunder in said arbitration and/or court proceeding(s). In addition, Sponsor agrees to compensate Aspen for all reasonable attorneys' fees and costs incurred by Aspen in connection with those matters concerning which Sponsor has agreed to pay or indemnify Aspen herein.

17. NOTICES. Any and all notices, payments, reports and other correspondence required hereunder shall be deemed to have been properly given or delivered when made in writing and delivered personally to the party to whom directed, or when sent by United States mail with all necessary postage or charges fully prepaid, and addressed to the party to whom directed at its below specified address (or a new address after written notice of such change is given to the other party).

Aspen Achievement Academy
c/o Aspen Education Group
17777 Center Court Drive, #300
Cerritos, CA 90703

Sponsor(s) Name _____
Address _____
City, State, Zip _____

18. AMENDMENTS. This agreement may be amended at any time upon mutual agreement of the parties hereto, but any amendment(s) must first be reduced to writing and signed by both parties in order to become effective.

19. WAIVER. A waiver by any party of any provision hereof, whether in writing or by course of conduct or otherwise, shall be valid only in the instance for which it is given, and shall not be deemed a continuing waiver of said provision, nor shall it be construed as a waiver of any other provision hereof.

20. PARAGRAPH HEADING. The paragraph headings of this Agreement are inserted only for convenience and in no way define, limit or describe the scope or intent of this Agreement nor affect its terms and provisions.

21. GOVERNING LAW/VENUE. This Agreement, and all matters relating hereto, including any matter or dispute arising between the parties out of this Agreement, tort or otherwise, shall be interpreted, governed, and enforced according to the laws of the State of California; and the Parties consent and submit to the exclusive jurisdiction and venue of the California Courts in Los Angeles County, California, and any qualified (American Arbitration Association-approved) arbitration service in the State of California, County of Los Angeles, to enforce this Agreement. The parties acknowledge that this agreement constitutes a business transaction within the State of California.

22. SEVERABILITY. In the event that any provision of this Agreement, or any operation contemplated hereunder, is found by a court of competent jurisdiction to be inconsistent with or contrary to any law, ordinance, or regulation, the latter shall be deemed to control and the Agreement shall be regarded as modified accordingly and, in any event, the remainder of this Agreement shall continue in full force and effect.

23. NUMBER. As used in this Agreement, the term "Sponsor" shall include all Sponsors, being the parent(s) and/or guardian(s) executing this Agreement; and singular pronouns shall include the plural and plural pronouns shall include the singular, whenever the context so requires.

24. ACKNOWLEDGEMENT/ENTIRE AGREEMENT. Sponsor hereby acknowledges that Sponsor has read this Agreement and that Sponsor understands and consents to all of its provisions; that this Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter hereof; and that all other prior agreements, promises, expectations and conditions, oral or written, between the parties are incorporated herein. Other than the express commitments set forth in this Agreement and the Program description, Aspen gives no warranties of any kind, express or implied, to either the Sponsor or the Student concerning the Program; and Sponsor acknowledges that Sponsor is not relying on any warranties or representations of any kind other than the express commitments of Aspen set forth herein.

25. BINDING EFFECT. This Agreement shall be binding upon and inure to the benefit of the parties hereto, their heirs, personal representatives, successors and assigns.

26. RELEASE OF INFORMATION. The parties authorize the release of the Student's information via E-mail, Internet technology, voice mail or US mail. While every effort will be made to maintain confidentiality, Aspen accepts no responsibility for the mis-transmission that could result in information becoming available to someone other than the intended receiver. Aspen shall handle all such protected health information (also "PHI") pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act ("HIPAA") of 1996.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the dates set forth below.

_____ Date: _____
Sponsor (father/guardian)

_____ Date: _____
Sponsor (mother/guardian)

Accepted:

_____ Date: _____
Aspen Achievement Academy

The Family Support Services Program

Critical Assessment Information

Dear Parents:

AAA's approach to providing the most effective, comprehensive and ethical treatment possible includes offering a thorough individual and family assessment. Timing and comprehensiveness yield crucial information which results in improved treatment effectiveness by providing:

- Diagnostic information necessary for guiding both parents and student in short term and long term treatment planning
- Critical information for improving treatment effectiveness
- Family involvement in the change process

Research shows that:

- When a student is in a wilderness program their defensiveness has dropped considerably and their thinking has become clearer. Thus more accurate results can be obtained than in almost any other setting.
- Assessment is most powerful when completed within 14-18 days after the student's arrival in the program. Resistance has dropped and information gathered can have it's most salient effect on treatment planning when implemented by the 3rd or 4th week of treatment.
- Family involvement through their own education pertinent to treatment needs enhances treatment effectiveness and increases the likelihood of lasting change.

Therefore we are pleased to provide the opportunity for your family to have the most thorough evaluation possible while at AAA.

Recommended Optional Psychological Assessment- This is a series of instruments designed to evaluate your teen as an individual, and is an extremely important assessment if your child has been diagnosed with any mental health or learning problems. This is a comprehensive assessment of personality features, academic progress and learning differences, substance abuse severity, anxiety features, mood disorder behavior problems and social relatedness. This is objective information of your teen's functioning in all areas including social, emotional and academic. This can be critical for short-term and long-term treatment and academic planning. Any testing that is older than one year, or any testing that has gaps in cognitive, emotional, or behavioral areas should be redone**. If your child has received complete psychological testing within the last 6 months, Please send a copy of the assessment along with the enrollment paperwork. Thank you.**

Family Assessment- Family assessment is a series of instruments designed to evaluate the system in which your child lives. This includes family dynamics, family context, and individual characteristics. Research shows that family involvement in treatment is an important factor in longevity of treatment gains. This provides information distinct from an individual psychological evaluation, but which is just as important and enlightening, and will lead to the family's most effective involvement in helping their teen. With home therapist involvement, this is an effective tool that will follow your family through your treatment now and in the future.

Recommended Optional Psychiatric Evaluation-We recommend a psychiatric evaluation for everyone who enters the program on medication or if evaluation/assessment suggests the necessity of medication. Although a teen must be stabilized on any current medications when entering the program, there are many differences and personal changes which might influence medication titration. We provide the opportunity for a "clean" look at your child, in a controlled environment, which might impact psychiatric decisions. The therapist for your child will schedule this with you if needed.

PSYCHOLOGICAL TESTING / Optional

The application of scientific methods to understanding cognitive, emotional and behavioral functioning.

The assessment procedures used will evaluate the child in three major categories:

Cognitive: IQ and or achievement testing to determine the strengths and weaknesses of a person's thinking in eleven domains including: general awareness, attention, memory, verbal comprehension, visual-spatial ability, computation, abstract thought, impulsivity, problem solving, social comprehension, and judgment. Obtain level of academic functioning and compare results to national norms. Rule out learning disabilities, ADD/ADHD, or nonverbal learning disability. Rule out thought disorders and screen for organic impairment.

Emotional: Assess emotional functioning and assess for depression, anxiety, deficits in identity formation, obsessive and compulsive disorders, and sleep disorders. Assess personality functioning. Obtain data regarding developmental and emotional age. Obtain data regarding family dynamics.

Behavioral: Screen for substance abuse. Screen for trauma and abuse. Screen for risk of self-harm, aggression, and treatment compliance or flight. Detect malingering and deceit. Screen for behaviors that are high risk, illegal, or violate the rights of others or major social values.

Psychological evaluations include clinical interviews, a write-up of test results, and consultation with parents and, when requested, with possible aftercare placements. Many boarding schools and residential treatment centers request test results to ensure that they are accepting students for whom they can be most helpful. Consequently, testing is an important component of treatment and aftercare planning.

Testing is done a minimum of two weeks after the student's arrival, which gives the student time to adjust to their surroundings.

Consent to Administer Psychological Testing

By signing below, I hereby agree to have my child participate in psychological testing. I understand that all battery protocols and all material generated from the assessments are the property of the Aspen Education Group Programs. I understand that information may come to light during this evaluation that must remain confidential, due to the content of the disclosure. I understand that the results of the assessments will be used by the staff of Aspen Education Group Programs to enhance the treatment of the child named below. Aspen Education Group has my permission to release information to any professional who is working with my child. Finally, I understand that no information will be shared with anyone else, or any other agency, without my permission

☐ **Yes, I agree to have my child participate in psychological testing at a cost of $2000.00**

Child's name _____ Parent's name _____
E-mail _____
Address _____
Phone numbers _____
Educational Consultant _____
Home Therapist and Other Professionals to contact _____
Signature _____ Date _____

METHOD OF PAYMENT ***Please Select a Method of Payment.***

☐ **Cashier's check payable to Aspen Achievement Academy**
Send payment to: *98 South Main Street, Loa,Utah 84747*

☐ **Wire Transfer** (F*ax the wire confirmation form to 435-836-2477)*
Please call and speak with Janette Hiskey for wire instructions

☐ **Use credit card listed below**

Am.Express/Visa/Mastercard | | | | | | | | | | | | | | | | | | |

Card expiration date:_____

Name Exactly As It Appears on the Card_____3 digit security code_____

✍**Signature of Cardholder:**_____**Date:**_____

FAMILY ASSESSMENT AND SUMMARY / Included

The Family Assessment and Summary will provide you with more knowledge and understanding enhancing your child's Aspen experience and supporting your child during aftercare. Family Assessment's are included in the Aspen Achievement Academy program at no additional charge.

The Family Assessment and Summary

- A psycho-educational program that addresses and integrates 3 treatment areas:
  1. Family Traits
  2. Individual Traits
  3. Family Context
- Identifies assets and liabilities in the 3 areas
- Develops a written ***customized*** growth plan and summary for your child and family
- Assists in maintaining progress during the transition from Aspen to aftercare by providing detailed, personalized recommendations and tools for the entire family to utilize.

The following assessments, along with consultations and recommendations, will be administered

1. *Family system assessment* including: **Family Adaptability and Cohesion, Parent-Adolescent Communication, Family Satisfaction.** Identifying strengths and weaknesses, family dynamics, issues and their causes.
2. *Marital/Couple assessment*. This will provide information on marital factors that are impacting your child's treatment effectiveness.
3. *Personality assessment* Uses the Hartman Color Code, a measure which helps you identify the *core motive* behind many of your behaviors.
4. *Substance abuse assessment* evaluates the role of substance use and abuse in the family.
5. *Readiness for change assessment* **The University of Rhode Island Change Assessment (URICA)** evaluates and identifies a person's readiness to change based on 4 stages: pre-contemplation, contemplation, action, and maintenance.

Consent to Administer Family Assessments

By signing below, I hereby agree to have my family participate in Family Assessments. I understand that all battery protocols and all material generated from the assessments are the property of the Aspen Education Group Programs. I understand that information may come to light during this evaluation that must remain confidential, due to the content of the disclosure. I understand that the results of the assessments will be used by the staff of Aspen Education Group Programs to enhance the treatment of the child named below. Aspen Education Group has my permission to release information to any professional who is working with my child. Finally, I understand that no information will be shared with anyone else, or any other agency, without my permission.

☐ **Yes, I agree to have my child participate in Family Assessments**

Child's name _____ Parent's name _____
E-mail _____
Address _____
Phone numbers _____
Educational Consultant _____
Home Therapist and Other Professionals to contact _____
Signature _____ Date _____

If you have questions please discuss with your Admissions Counselor

AFTER CARE TRANSITION SPECIALIST DISCLOSURE

The Aftercare Transition Specialist provides the following:

Education on Continuum of Care: Broad overview of the possible next steps and resources available to you and your child following the wilderness program.

Proactive Planning: Information about how to prepare for a successful transition following your child's wilderness experience whether the next step is a residential treatment center or transition home with aftercare support. Preparation and forethought prior to having to make this decision allows for a more effective transition for everyone and helps to preserve the current investment made by you and your child.

Integration of Service Providers: Collaboration and communication helps minimize the risk of disruption and/or regression as your child moves from one environment to the next. By beginning the process of coordinating these resources prior to discharge, you and your child are better prepared to continue the progress that is made during the wilderness experience.

CONSENT

I hereby agree to allow an Aftercare Transition Specialist to participate in a discussion of treatment options for the child named below. I understand that this discussion(s) may be with educational consultants, mental health professionals, and institutions. I also understand that the purpose of this conversation is solely for providing aftercare resources following my child's discharge from the wilderness program. Treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required by law.
I understand that there is no cost associated with this discussion. The Protected Health Information that may be discussed may include *medical history, mental, physical condition, treatment, and financial* related information. Aspen Education Group has my permission to release information to the Aftercare Transition Specialist
Name of Minor: _____Relationship to Minor:_____
Name of Parent or Guardian (Print) _____
Signature: _____Date: _____
This authorization expires:_____
Check the below boxes (indicates your understanding)
□ It is noted that I may refuse to sign this Authorization at anytime.
□ I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the following address:
Program's address: ____98 South Main Loa, UT 84747_____
□ My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization
□ I understand that I have a right to receive a copy of this Authorization
□ I understand that the information to be released or disclosed may include those relating to sexually transmitted diseases, AIDS or HIV, alcohol / drug / substance abuse under 42 CFR 2.31I authorize the release or disclosure of this information after having specifically considering and expressly waiving those federal consent requirements and restrictions.

CONSENT FOR DISCUSSION AND RELEASE OF PROTECTED HEALTH INFORMATION

NOTICE OF RIGHTS

Check the below boxes (indicates your understanding)
□ It is noted that I may refuse to sign this Authorization at anytime.
□ I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the following address:
Program's address: ___98 South Main Loa, UT 84747_____
□ My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization
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Aspen Achievement Academy
98 S. Main Loa, Utah 84747
800-283-8334

Dear Aspen Parent:

Attached, please find Form ICPC – 100A and 100B (the Interstate Compact Placement Request Form). This is an Interstate Compact, which in its essence informs the state of Utah that your child is coming into their state as a temporary resident. It, in turn, notifies your home state that your child will be temporarily residing in Utah. It is an agreement between the 50 states that, should your child ever be in need of government services, the receiving state (Utah) is agreeing to provide care and supervision while your home state agrees to bear the cost. While this form is generally a formality for Aspen placements, Aspen is required to have an approved Interstate Compact for each enrollee.

(100A) If you reside in any state other than Utah, it is imperative that Section I is completely filled out, and, the area labeled, "Legal Status", in Section II, is completed. In addition, your signature must appear in the lower portion of Section III labeled, "Signature of Sending Agency or Person", and dated.
(100B) Section I must be filled out as well as a signature in Section IV where it is marked "Person/Agency Supplying Information. **PLEASE DO NOT FORGET TO SIGN AND DATE.**

Any incomplete ICPC will be sent back to you to complete and or sign.

Thank you for your promptness through this process, which allows us to help your children. If you are in need of further assistance, I can be reached between the hours of 8:00 a.m. and 5:00 p.m. Mountain Standard Time at (435) 836-2472.

Sincerely,

Kori Brown

Kori Brown
Admissions Intake Director

INSTRUCTIONS FOR COMPLETING FORM ICPC-100A & 100B
(INTERSTATE COMPACT PLACEMENT REQUEST FORMS)

To make the completion of this form as easy as possible, I have highlighted the sections and signature lines in red on the ICPC forms.

100A

Section I: IDENTIFYING INFORMATION

Enter the full legal name, sex, ethnic group and birth date of the child for whom this placement is proposed.

Use the following cods to enter the child's ethnicity: W=White; H=Hispanic; B=Black; A=Asian or Pacific Islander; AI=American Indian or Alaskan Native; OT-All other race/ethnic categories; UK=Unknown

Enter the names of the legal mother and legal father. In cases where an adoption has been finalized, the adoptive parents will be the legal parents. If the parent(s) is deceased, enter "deceased" after the parent's name. If parental rights have been voluntarily relinquished or terminated by the court, indicate in parenthesis beside the name.

Enter the complete name, address and telephone number of the agency or person who is responsible for planning for the child and who is financially responsible for the child.

Section II: PLACEMENT INFORMATION

Legal Status Definitions:
Sending Agency Custody/Guardianship: child is in full legal custody or guardianship of the public social service agency or a licensed private child –placing agency.

Parent Relative Custody/Guardianship: child is not under the jurisdiction of either an agency or the court but is still the full legal responsibility of parent or relative.

Section III: SERVICES REQUESTED

Please sign and date where it is asking for the signature of the sending agency or person

100B

Section I: IDENTIFYING INFORMATION

Enter Child's Name, Birth Date, Mother's Name, Fathers Name

Section IV: SIGNATURES

Sign the area marked Person/Agency Supplying Information

No other sections require information from parents

ICPC 100A
REV. 8/2001

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN
REPORT ON CHILD'S PLACEMENT STATUS

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

TO: **FROM:**

SECTION I - IDENTIFYING DATA

Notice is given of intent to place - Name of Child:

Social Security Number: | ICWA Eligible ☐ Yes ☐ No

Sex: | Date of Birth | Title IV-E determination ☐ Yes ☐ No ☐ Pending

Ethnicity: Hispanic Origin: ☐ Yes ☐ No ☐ Unable to determine/unknown

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Native Hawiian/ Other Pacific Islander
☐ Black or African American
☐ White

Name of Mother:

Name of Father:

Name of Agency or Person Responsible for Planning for Child: | Phone:

Address:

Name of Agency or Person Financially Responsible for Child: | Phone:

Address:

SECTION II - PLACEMENT INFORMATION

Name of Person(s) or Facility Child is to be placed with:
Aspen Achievement Academy

Soc Sec # (optional):
Soc Sec # (optional):

Address:
98 So. Main, Loa Utah, 84747

Phone: **435-836-2472**

Type of Care Requested:

☐ Foster Family Home
☐ Group Home Care
☐ Child Caring Institution
X Residential Treatment Center
☐ Institutional Care-Article VI, Adjudicated Delinquent
☐ Parent
☐ Relative (Not Parent)
Relationship: _____
☐ Other: _____

☐ ADOPTION
☐ IV-E Subsidy
☐ Non IV-E Subsidy
To Be Finalized In:
☐ Sending State
☐ Receiving State

Current Legal Status of Child:

☐ Sending Agency Custody/Guardianship
☐ Parent Relative Custody/Guardianship
☐ Court Jurisdiction Only
☐ Protective Supervision
☐ Parental Rights Terminated-Right to Place for Adoption
☐ Unaccompanied Refugee Minor
☐ Other:

SECTION III - SERVICES REQUESTED

Initial Report Requested (if applicable):
☐ Parent Home Study
☐ Relative Home Study
☐ Adoptive Home Study
☐ Foster Home Study

Supervisory Services Requested:
☐ Request Receiving State to Arrange Supervision
☐ Another Agency Agreed to Supervise
☐ Sending Agency to Supervise

Supervisory Reports Requested:
☐ Quarterly
☐ Semi-Annually
☐ Upon Request
☐ Other:

Name and Address of Supervising Agency in Receiving State:

Enclosed: ☐ Child's Social History ☐ Court Order ☐ Financial/Medical Plan ☐ Other Enclosures
☐ Home Study of Placement Resource ☐ ICWA Enclosure ☐ IV-E Eligibility Documentation

Signature of Sending Agency or Person: | Date:

Signature of Sending State Compact Administrator, Deputy or Alternate: | Date:

SECTION IV - ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC

☐ Placement may be made ☐ Placement shall not be made

REMARKS:

Signature of Receiving State Compact Administrator, Deputy or Alternate: | Date:

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN
REPORT ON CHILD'S PLACEMENT STATUS

TO: **FROM:**

SECTION I - IDENTIFYING INFORMATION

Child's Name: _____ Birthdate: _____

Mother's Name: _____ Father's Name: _____

SECTION II - PLACEMENT STATUS

☐ Initial Placement of Child in Receiving State **Date Child Placed in Receiving** _____

Name of Resource: _____

Address: _____

Type of Care: _____

☐ Placement Change Effective Date of Change: _____

Name of Resource: _____

Address: _____

Type of Care: _____

SECTION III – COMPACT PLACEMENT TERMINATION

☐ Adoption Finalized ☐ In Sending State ☐ In Receiving State ☐ Court Order Attached

☐ Child Reached Majority/Legally Emancipated

☐ Legal Custody Returned to Parent(s) ☐ Court Order Attached

☐ Legal Custody Given to Relative ☐ Court Order Attached

Name: _____ Relationship: _____

☐ Treatment Completed

☐ Sending State's Jurisdiction Terminated with the Concurrence of the Receiving State

☐ Unilateral Termination

☐ Child Returned to Sending State

☐ Child Has Moved to Another State

☐ Proposed Placement Request Withdrawn

Name of Placement Resource: _____

☐ Approved Resource Will Not Be Used for Placement

Name of Approved Placement : _____

☐ Other (Specify): _____

Date of Termination: _____

SECTION IV - SIGNATURES

Person/Agency Supplying Information: Date:

Compact Administrator, Deputy or Alternate: Date:

ICPC 100B
REV. 8/2001