Application Checklist

Now that your child has been approved for admission, the next step is completing this application packet. As you fill out this packet, should you have any questions, please call Russ Pryor, the Director of Admissions, or Randi Nelson, Admissions Coordinator, at (801) 825-5222, and we will be happy to help you. We are available 9am-5pm MST, after hours you may call Russ's mobile phone at (801) 678-2547 or Randi's mobile phone at (801)678-1658. We look forward to working with you and your child.

As a reminder, please take note of the following important items:

THIS APPLICATION MUST BE FULLY COMPLETED, WITHOUT ALTERATION, AND FAXED TO US PRIOR TO ADMISSION. LEGALLY, ACCORDING TO JCAHO REGULATIONS, WE ARE UNABLE ACCEPT ANY CHILD INTO THE HOSPITAL WITHOUT FIRST HAVING THE APPROPRIATE SIGNED DOCUMENTS. This means that if we have not received the paperwork before your child arrives, the child must be kept off the premises until we do receive it.

_____ Please remember to include a copy of the front and back of your insurance card, with your child's name and birth date on the Insurance Card Form.

_____ Section 4 of the Admissions Agreement has a line that needs to be initialed.

_____ At time of admission, a deposit of $18,000 is due.

_____ Once you have worked out an admissions date with the Admissions Director, your travel or transport arrangements should be made as soon as possible. (Our admission hours are between 9:30am and 3:30pm.) Please notify Russ or Randi of your child's approximate arrival time on that date, so we can plan the admission accordingly.

_____ You will notice that this application packet contains two "consent for disclosure" forms. If you have an educational consultant, please fill one out with your consultant's name. Then, please sign the second form, but do not fill in the party to release information to. That way, we will be able to witness over the phone when you give us permission to communicate with another professional or program, without you having to fill out a new form and fax it every time.

Thank you for your attention to these details. Again, please don't hesitate to call with any questions.

FAX to: 801-825-8222.
Or scan and email to rpryor@aspenassessment.com or
rnelson@aspenassessment.com

INSURANCE CARDS

Insurance Card Front (Please enlarge to fit in Box)

Insurance Card Back (Please enlarge to fit in Box)

Child's Name: _____ Child's DOB: _____

Insurance Company: _____ Policy Number: _____

Group Number: _____ Subscriber Name: _____

Insurance Phone #: _____ Parent Phone Number: _____

PLEASE SCAN AND EMAIL (OR) FAX

EMAIL: rpryor@aspenassessment.com **(OR)** rnelson@aspenassessment.com

FAX: (801)825-8222

Aspen Institute
ADMISSION RECORD

Resident Information

Account Number: Office Staff			Resident Record Number: Office Staff			
Resident Last Name:	First:		Initial:	Resident Social Security Number:		Sex:
Current Guardianship/Legal Status:				Court Status:		
Age	Date of Birth:	Place of Birth:	Mother's Email		Father's Email	
Resident's Address:	City/State:	Zip:	Phone:			
Religion:	Last School Attended:	Race:	Arrival Mode:	Readmission:	Marital Status: **N/A**	
Type of Employment: **N/A**		Place of Employment: **N/A**		Referral Source:		

Parent/Guardian Information

Parent/Guardian #1	Address:	City/State Zip	Phone **H-**
Parent/Guardian #2 Name:	Address:	City/State Zip	Phone **H-**
In Case of Emergency Notify:	Emergency Phone:	Relationship:	Custody of Resident:

Financial Information

Guarantor #1 Name:	Address:	City/State	Zip	Cell	SS #:
Guarantor's Employer	Address:	City/State	Zip	Phone	Email:
Guarantor #2 Name:	Address:	City/State	Zip	Cell	SS #:
Guarantor's Employer	Address:	City/State	Zip	Phone	Email:

Insurance #1	Policy Number:	Group Number	Subscriber	Phone:
Insurance #2	Policy Number:	Group Number:	Subscriber	Phone:
Mother's Birth day		Father's Birth day		

Diagnostic Information (OFFICE STAFF OLNY)

Date of Admit ACUTE:	Time:	By Whom:	Date of Admit SUB-ACUTE:	Attending Physician:	Therapist:
Provisional Diagnosis:		Admitting Diagnosis:			

Discharge Information

Date:	Time:	LOS	Discharge Disposition:	Consulting Physician:
Final diagnosis; Axis I: Primary (DSM)				
Final Diagnosis; Axis I: Secondary (DSM)				

Signature of Attending Physician:	Date:

ASPEN INSTITUTE

Communication Form

Student Contact Information	
Residents Name	**Residents ID**

Visitation List

Name	Relationship

Mail List

Name	Relationship	Address	Send/Receive
			□ Send □ Receive
			□ Send □ Receive
			□ Send □ Receive
			□ Send □ Receive
			□ Send □ Receive
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			□ Send □ Receive

Parent Email

Parent Name	Parent Email

Mail Policy

When residents desire to mail any material to any person, they are required to provide the material to the Institute, sealed, in an envelope or other package, without postage. The Institute then takes the package or envelope, without opening or inspecting the contents, and forwards the envelope or package to the resident's parent or legal guardian. Likewise, when any mail from any person other than the parent or legal guardian arrives at the Institute addressed to a resident, the Institute takes the mail, unopened, and delivers it to the parents of the resident. At the time of admissions you will be given a Resident ID Code that must be on all coming mail.

I, _____ Parent/Legal Guardian of_____

Resident Consent Form

Our Notice of Privacy Practices contains information about how we may use and disclose protected health information about the minor child. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy from our website, www.aspenassessment.com, or by calling the Institute at (801) 825-5222.

You have the right to request that we restrict how protected health information about the minor child is used or disclosed for treatment, payment, or health care operation. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about the minor child for treatment, except where we have already made disclosures in reliance on your prior consent.

_____

Print Name of Minor Child

_____

Print Name of Parent/Guardian

_____ _____

Signature and Relationship to Minor Child Date

Consultation Release Form

Purpose:	During the course of your child's stay at the Institute, it may become necessary for he/she to seek treatment from an outside consultant and/or services such as Dentist, OB/GYN, Orthopedic, Optometry, E.N.T.,ect. You are responsible for the cost associated with these services. I understand that the Institute will seek parent/ guardian approval prior to scheduling such consultations.

Acknowledgment

I,_____, am aware that I am responsible for all costs related to outside
(**name of parent/Guardian)**

consultation services in behalf of _____ during his/her stay at the
(**name of Resident)**

Institute. I am aware that the provider of the consultation service will bill me and /or my insurance company for the services provided.

Insurance Information

Insurance # 1;_____ Phone #:_____
Policy Number: _____ Group Number:_____
Insurance # 2: _____ Phone #: _____
Policy number:_____ Group number: _____

Signature (Parent/ Guardian **Date**

Medication and Dosage

Dear Parent/Guardian,

In an effort to coordinate your child's medication administration, it is necessary for you to complete the Prescription Drug Enrollment form. This form allows us to fill the medications that the Physician has prescribed in a timely manner without delaying the administration to your child

Please indicate what medication your child is currently taking. Efforts will be made to continue these medications until reviewed with the attending Physician. After admission, permission will be obtained from you prior to starting any new medication (Except in an emergency situation)

If you have further questions or concerns, please contact the nursing staff at (801) 825-5222.

Thank you for your assistance in this matter as it will expedite the process in obtaining and administrating medication *for* your child

Medication and Dosage Your Child is Currently Taking

_____
_____
_____
_____

I hereby authorize the Institute to continue the medication my child is currently taking.

_____
Signature/Relationship to Child. Date

ASPEN INSTITUTE

Immunization Record Status and Consent Form

Pursuant to licensure and accreditation requirements, the Institute is charged with the obligation to maintain an infection control program of which the immunization of residents is a vital part. If you are unable to provide immunization records before admission to the Institute, please complete the following until the immunization records can be obtained.

Immunization	Recommended Age	Year Completed
DTP, oral polio vaccine	2 month	
DTP, oral polio vaccine	4 month	
DTP, oral polio vaccine	6 month	
MMR (measles, mumps, rubella)	15 month	
DTP, oral polio vaccine	15 month	
MMR (measles, mumps, rubella)	4-6 years	
DTP, oral polio vaccine	4-6 years	
TD (tetanus, diphtheria)	14-16 years	

I, (your name) _____, understand that I am responsible for documentary proof to verify that immunizations are current of (resident name) _____ and if deficient to have the appropriate vaccines administered in a timely fashion.

_____

Parent/Guardian Signature Date

_____

Witness Date

In cases were a resident would like to be inoculated while at the Institute, the facility will provide the procedure through the Davis County Health Department.

Consent for Disclosure of Confidential Information

FOR THE RECIPIENT OF THE INFORMATION:

The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted under Federal rules. With respect to information regarding alcohol or drug abuse treatment, a general authorization for the use or release of medical or other information is NOT sufficient. In such a case, Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

1. Pursuant to Federal Guidelines concerning my right to confidentiality, I, _____ DOB: _____
   (Patient/Resident/Student Name)
   authorize _____
   (Person/Organization making disclosure)
   to release/disclose confidential information to: _____
   (Person/Organization receiving disclosure)

2. I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. The information to be used or released includes:

   - ❑ Psychological Evaluation
   - ❑ Psychiatric Evaluation
   - ❑ Psycho-Social History
   - ❑ Discharge Summary
   - ❑ Laboratory Data
   - ❑ Treatment Plans
   - ❑ Consultation Reports
   - ❑ Assessments
   - ❑ Progress Notes
   - ❑ Medical Records
   - ❑ X-ray Reports
   - ❑ Medication Records
   - ❑ Monthly Progress Report
   - ❑ Parent Check In
   - ❑ Other: _____
   - ❑ Verbal Communication with: _____

3. The above information is to be released for the following purpose:

   - ❑ For evaluative purposes to determined if the patient/resident/student meets admission criteria for the Institute.
   - ❑ For continuation of care at the Institute.
   - ❑ For continuation of care at: _____
   - ❑ Other: _____

4. I authorize the release of such information by mail, fax, regular telephone, and/or cellular phone contact.

5. I understand that unless I revoke the authorization earlier, this authorization will automatically expire 60 days after the resident's discharge from the Institute or on: (date, event, condition): _____

6. I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.

7. This authorization is limited to only that information that I have requested above to be used or disclosed to the person/facilities named herein. I hereby release the Institute from all legal responsibilities or liability that may arise from the use of disclosure of medical records and other health information in reliance on this authorization.

8. Pursuant to Utah State rules, I understand that in case I am below the age of 18, my parent/legal guardian reserves the right to sign this release without my expressed verbal or written consent.

Certification: I certify that I am (check whichever applies):

- ❑ The patient/resident/student, and the identification that I have provided is true and correct.
- ❑ The patient/resident/student authorized representative, and the identification and proof of authority that I have provided are true and correct. My relationship to the resident is that of: _____

Resident Signature: _____ Date: _____

Parent/Legal Guardian Name:_____ Date: _____
Print Signature

Aspen Institute Witness: _____ 2nd Witness (if by phone): _____ Date: _____

Consent for Disclosure of Confidential Information

FOR THE RECIPIENT OF THE INFORMATION:

The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted under Federal rules. With respect to information regarding alcohol or drug abuse treatment, a general authorization for the use or release of medical or other information is NOT sufficient. In such a case, Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

1. Pursuant to Federal Guidelines concerning my right to confidentiality, I, _____ DOB: _____
(Patient/Resident/Student Name)
authorize _____
(Person/Organization making disclosure)
to release/disclose confidential information to: _____
(Person/Organization receiving disclosure)

3. I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. The information to be used or released includes:

- ❑ Psychological Evaluation
- ❑ Psychiatric Evaluation
- ❑ Psycho-Social History
- ❑ Discharge Summary
- ❑ Laboratory Data
- ❑ Treatment Plans
- ❑ Consultation Reports
- ❑ Assessments
- ❑ Progress Notes
- ❑ Medical Records
- ❑ X-ray Reports
- ❑ Medication Records
- ❑ Monthly Progress Report
- ❑ Parent Check In
- ❑ Other: _____
- ❑ Verbal Communication with: _____

3. The above information is to be released for the following purpose:

- ❑ For evaluative purposes to determined if the patient/resident/student meets admission criteria for the Institute.
- ❑ For continuation of care at the Institute.
- ❑ For continuation of care at: _____
- ❑ Other: _____

9. I authorize the release of such information by mail, fax, regular telephone, and/or cellular phone contact.

10. I understand that unless I revoke the authorization earlier, this authorization will automatically expire 60 days after the resident's discharge from the Institute or on: (date, event, condition): _____

11. I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.

12. This authorization is limited to only that information that I have requested above to be used or disclosed to the person/facilities named herein. I hereby release the Institute from all legal responsibilities or liability that may arise from the use of disclosure of medical records and other health information in reliance on this authorization.

13. Pursuant to Utah State rules, I understand that in case I am below the age of 18, my parent/legal guardian reserves the right to sign this release without my expressed verbal or written consent.

Certification: I certify that I am (check whichever applies):

- ❑ The patient/resident/student, and the identification that I have provided is true and correct.
- ❑ The patient/resident/student authorized representative, and the identification and proof of authority that I have provided are true and correct. My relationship to the resident is that of: _____

Resident Signature: _____ Date: _____

Parent/Legal Guardian Name:_____ Date: _____
Print Signature

Aspen Institute Witness: _____ 2nd Witness (if by phone): _____ Date: _____

CONSENT FOR OVER THE COUNTER MEDICATION (OCM) ADMINISTRATION

Resident Name: _____ Admit Date: _____

During the stay of a resident at the Institute, it may become necessary to administer over the counter medication (OCM) for symptom relief. The medical and/or nursing staff will decide which medications are indicated for the illness. Nursing staff dispenses the following medications with administration guidelines outlined by the physician.

If there are any medications **YOU DO NOT WANT YOUR CHILD TO RECEIVE,** please indicate by marking that particular medication.

- ❑ Ibuprofen (Advil, Motrin)
- ❑ Benadryl
- ❑ Cough Drops
- ❑ Guiatuss DM expectorant (Dextromethorphan)
- ❑ Hydrocortisone Cream
- ❑ Maalox / Milk of Magnesia
- ❑ Rolaids/Tums
- ❑ Sudafed
- ❑ Tinactin Cream
- ❑ Bacitracin Zinc Ointment
- ❑ Aceteminophen (Tylenol)
- ❑ Fiber Tablets
- ❑ Artificial Tears
- ❑ Chloreseptic throat spray
- ❑ Magic Mouth Wash (Benadryl, Maalox, Hydrogen peroxide)
- ❑ Sunscreen
- ❑ Pepcid AC
- ❑ Claritin
- ❑ Other: _____

If the resident has allergies to agents he/she may come in contact with suddenly and/or unpredictable such as bee stings, or hidden food items that have cause severe reactions, it is imperative that you indicate this on the Health History section of our Health History Form and on this form. Medication such as an Epi-pen should be made available at all times when potential contact with an allergen is possible.

Allergies (medication, food, other):

_____

_____

Parent/Legal guardian Signature Date

Island View Pharmacy
2038 W. 1900 S.
Syracuse, UT 84075
(801)773-7899 Fax (801)773-7738

Agreement for Services

Island View Pharmacy provides services to Aspen Institute for Behavioral Assessment's patients including, but not limited to: Medical supplies, medications, and packaging. Patients who receive services from Island View Pharmacy must complete the following agreement. Island View Pharmacy will bill the appropriate/ insurance when applicable. But the patient/responsible party will be responsible for any non-covered charges. If no insurance/agency is indicated, Island View Pharmacy will bill the patient/responsible party directly through a valid credit card, as per Aspen Institute's policy. Island View Pharmacy will not accept medication from outside pharmacies or mail-order pharmacies.

Resident Information (please print): Name_____ Male ☐ / Female ☐
S.S# _____ Date of Birth _____
Diagnosis_____ Allergies _____ Physician _____

Billing Status (check all that applies):

☐ Private Pay – We will bill the responsible party's credit card monthly.
☐ Private Pay with Insurance – We will bill the insurance directly whenever possible the responsible party's credit card will be billed for Deductible, co-pay, co-insurance, non-covered charges, and denied claims.
☐ Medicaid – We will bill Medicaid directly. The responsible party's credit card will be billed for any co-pay or non-covered charges.

Please note: A $10.00 service fee will be added to your pharmacy charges by Island View Pharmacy. This fee covers the cost of printing and updating Medication Administration Record (MAR's) as well as on-site services by a licensed pharmacist for consultation services.

Insurance Information (Other than Medicare):
Insurance Company _____

Phone Number _____ Policy Holder (If different that Resident) _____

Policy Number_____ Group Number _____

****** Please attach a copy of the Insurance card (front and back) with this sheet.**
Failure to do so could result in a failure to bill the insurance****

Responsible Party's (must have at least two (2) contacts):
Send statements to (Billing Address) Mr. /Mrs. /Ms. _____
Relationship to Resident _____
Street _____ City _____State _____
Zip Code _____ Phone _____
Credit Card Number **(REQUIRED)** _____ EXPIRATION: _____
Drivers License Number **(REQUIRED)** _____EXPIRATION:_____
Is the credit card Billing address the same as above? Yes_____ No _____ if no, please provide credit card billing address below:
Street _____ City _____
State _____ Zip _____

Emergency contact: Mr. / Mrs. / Ms. _____
Relationship to Resident _____
Street _____City _____ State _____ Zip _____
Phone _____

Please read and sign: I understand that by signing this agreement I indicate my wish to purchase health care products/services from Island View Pharmacy. I will pay for any co-pays, non-covered items, and charges that incur while under this agreement. I authorize Island View Pharmacy access to the above-mentioned patient's medical records for proper medication assessment. By signing I also indicate that I have received a Notice of Privacy Practices. I understand that this notice explains the uses and disclosures of protected health information (PHI) that may be made by Island View Pharmacy as well as my rights as a patient and Island View Pharmacy's duties with respect to (PHI). If my account is sent to collections, I agree to pay collection fees.

_____ _____
Resident (or) Responsible Party's Signature Date of Agreement

ADMISSION AGREEMENT

This agreement ("Agreement") is entered into by and between the Aspen The Institute for Behavioral Assessment, L.L.C., a Delaware limited liability company, (hereinafter "The Institute") *operating as* ***The Institute,*** a licensed program which is described in the program materials that Sponsor has received previously and which is made a part of this Agreement by reference (the "The Institute") and _____, the parent(s) and/or guardian(s) of the Resident (hereinafter the "Sponsors"). Sponsors'address is: _____, and phone number is: _____.

In consideration of the mutual promises set forth in this Agreement, The Institute 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: _____ whose birth date is_____(hereinafter the "Resident"), and that Sponsor desires to and does hereby contract with The Institute for the Resident's enrollment in the Program according to the terms and conditions of this Agreement. In entering into and performing under this Agreement, The Institute 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 The Institute, and Sponsor expressly warrants the truth and accuracy of the same.

2. **TERM OF AGREEMENT/CUSTODY.** This Agreement shall commence on the day of admission which is: _____ and remain in effect until the child's discharge date. On the day of admission, Sponsor shall transfer, by a Power of Attorney in the form received and executed by Sponsor, temporary custody of the Resident to The Institute for the duration of the admission period, or until the Resident attains the age of eighteen (18), unless the Resident (a) has otherwise been placed in the custody of The Institute by a court of proper jurisdiction or (b) voluntarily consents in writing to remain in the Program for any period of time beyond said eighteenth (18th) birthday.

3. **PROGRAM COSTS AND PAYMENT TERMS.**
   A. PROGRAM FEES. The Resident is accepted with the expectation that the Resident will complete the individual master treatment program. The Program fee per month excludes the cost of psychotropic and other medications, laboratory fees, specialty testing, and medical services as may be necessary. Physician fees are also excluded from the daily program cost. Sponsor agrees to pay all attorney fees, court costs, filing fees, and charges of commissions that may be assessed by any collection agency retained to pursue collection of any outstanding sums.

   B. SCHEDULE AND METHOD OF PAYMENT OF PROGRAM FEES; LATE FEES.
      (1) At the time of admission, sponsors shall pay 1) a deposit for the first 30 days of treatment. (For specific dollar amounts, please refer to the Financial Agreement). This initial payment may be paid by check.
      (2) All subsequent payments shall be paid by accepted credit card (VISA, Mastercard or American Express), checks, wire transfer or pre-authorized electronic check debits (ACH).
      (3) Sponsor shall also provide a valid credit card number with a credit capacity equal to dollar amount of one months' cost of the daily rate fee at the time of admission. In the event that a subsequent payment is not paid when due, Sponsor authorizes the program to charge the past due amount, including late fees, to the credit card number provided by the Sponsor at the time of admission.
      (4) Payments are due the 1st day of the month of service. For example, October payment is due October 1st. Payments not received in the current due month of service are subject to a $250 late fee and may result in discharge of the resident from the Institute. Upon discharge, the account must be paid in full. With the exception of preliminary discharge summary and associated diagnostic/treatment information, resident records will not be released after a resident discharges until all payments and fees are paid in full.
      (5) Residents with resident loans must provide a copy of an executed promissory note from the lending institution prior to admission. Actual funding must take place within ten days of admission. Residents receiving school district/mental health assistance must provide the program with written pre-approval from the district and county mental health before admission. Sponsor is responsible for payment of all tuition and fees not paid.

   C. FEE INCREASES. The current daily rate fee is subject to increases upon 60-day notice.

D. EARLY WITHDRAWAL OF RESIDENT. If Sponsor or authorized third party withdraws Resident before completion of the individual master treatment plan, **Sponsor understands and agrees that Sponsor shall immediately (1) pay all outstanding account balances and payments through the discharge date.**

E. ADDITIONAL COSTS AND EXPENSES. In addition to the treatment fee, Sponsor agrees to pay for the following expenses of the Resident: transportation from the Resident's current residence to Syracuse, Utah, and return transportation to the Resident's current residence; food and lodging expenses for any holding period before admission to the Institute and/or after discharge from the Institute; all medical, dental, medical-surgical hospital, prescription medication, assessment, specialty testing not included in the daily per diem rate, and related expenses incurred by or for the Resident, and all required personal items specified in the resident clothing list. Sponsors are also responsible for any additional escort fees required for transporting Resident to and/or from the Institute to another location (i.e., airport, doctor's appointment or other facility), outside the normal business hours (i.e. business hours are Monday-Saturday 9:00 am – 4:00 pm, with the exception of formal holidays).

F. 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 Resident, whether owned, leased, or controlled by The Institute or any third party, and (2) any personal injury to any The Institute personnel, other residents or third parties caused, in whole or in part, by the Resident; and to promptly reimburse The Institute for any costs and expenses, including legal fees, it may incur in connection therewith.

G. RUNAWAY EXPENSES. In the event the Resident runs away from The Institute, The Institute will make every reasonable effort to find the Resident and return the Resident to the Institute or to the Sponsor. An accounting of the expenses incurred by The Institute in finding and returning the Resident 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.

H. LOSS OR DAMAGE TO RESIDENT'S PROPERTY. The Institute is not liable for any loss of, or damage to any of the Resident's property. The Resident is fully responsible for the same at all times.

I. SUBCONTRACTING. Sponsor agrees and consents to The Institute's subcontracting certain services to be rendered under this Agreement to persons or entities deemed by The Institute to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both parties. The Institute is not responsible for the services provided by such third-party contractors and is hereby released from any liability arising from such services.

J. NURSING CARE. The Institute provides only general nursing care 24 hours/day unless, upon orders of the Resident's physician/nurse practitioner, the Resident is provided more intensive nursing care. If the Resident's condition is such as to need the service of a special duty nurse, it is agreed that the Sponsors must arrange such. The Institute shall in no way be responsible for failure to provide the same and is hereby released.

K. ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY.
In consideration of services rendered or to be rendered, sponsor irrevocably assigns and transfers to The Aspen Institute for Behavioral Assessment all rights, title and interest in the benefits payable for services rendered by The Institute provided for in the listed policy(ies) of insurance, but shall not be construed to be an obligation of The Institute to pursue any such right or recovery provided, however, this assignment and transfer shall not take away Sponsor standing to make claim or sue for benefits individually, should coverage be denied by any insurance carrier(s). Sponsor authorizes the insurance company(ies) to pay directly to The Institute all benefits due under said policy(ies) by reason of services rendered.

4. **ASSUMPTION OF RISKS; RELEASES AND INDEMNITIES.** Sponsor acknowledges that The Institute offers a some sports, exercise and recreational activities which can pose serious hazards and dangers, known and unknown, including but not limited to, emotional and physical injuries, illness or death that may arise from strenuous cardiovascular activities, exposure to the elements, plants and animals, running away from the Institute, "acts of God" (nature), the ropes course, stress, involvement with other residents, self-inflicted injuries, and transportation to and from activities. Sponsor understands that in participating in the Institute, Resident will be in locations and using facilities where 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 Resident are voluntarily participating in the Institute with knowledge of the dangers involved and agree to accept any and all risks.

In consideration for being permitted to participate in all aspect of resident services at the Institute, Sponsor agrees to not sue, to assume all risks and to release, hold harmless and indemnify The Institute 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 Education Group, Inc. (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 Resident 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 Resident's participation in any aspect of the Program, 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 Resident as a result of their participation in any aspect of the Program. 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.

Resident is physically capable of participating in resident services offered at the Institute, and his or her medical care provider has approved his or her participation. If Sponsor is aware that Resident is under treatment for any physical infirmity, ailment or illness, Resident's medical care provider knows of and has approved Resident's participation in the Institutes program. Sponsor acknowledges that Sponsor, and Sponsor alone, is solely responsible for Resident's personal health and safety, and the personal property Resident 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 procure and/or maintain 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 Resident 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 Resident, including, without limitation, claims related to or arising out of the Minor's participation in the Program. **Initials:** _____.

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

6. **AUTHORIZATION FOR SEARCH AND SEIZURE.** Sponsor hereby authorizes The Institute personnel to search the person and personal effects of the Resident at any time. The Institute is further authorized to confiscate any and all items deemed by The Institute to be contraband or counterproductive to the Resident's successful completion of the Program. The disposition of all items confiscated by The Institute shall be left to the sole discretion of The Institute.

7. **AUTHORIZATION FOR BEHAVIOR MODIFICATION/THERAPEUTIC HOLDS AND SPECIAL TREATMENT PROCEDURE (STP).** Sponsor hereby authorizes The Institute personnel to therapeutically hold, restrain, seclude, control and detain the Resident by the exercise of necessary techniques and holds when deemed necessary by The Institute for purposes including but not limited to escorting the Resident to and from the Institute's location, returning the Resident to the Institute if the Resident runs away, or preventing the Resident from jeopardizing the Resident'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 Resident until Sponsor or any personnel of The Institute arrive, at which time

The Institute personnel may re-obtain custody or control of the Resident or authorize continued custody by the law enforcement agency until travel is arranged for the Resident's return home.

8. **BENEFITS AND RISK ASSOCIATED WITH TREATMENT.** Sponsor hereby acknowledges to have received a Parent/Resident Handbook, which delineates the benefits and risk associated with the treatment provided at The Institute. Throughout the stay, the sponsor may ask for further clarification with regard to the benefits and risk associated with treatment.

9. **STILL PHOTOGRAPH AND DIGITAL VIDEO IMAGES AUTHORIZATION.** Sponsor gives permission to The Institute staff to take still photographs and digital videos of the Resident for identification and baseline measure purposes. Sponsor further acknowledges that those photographs and video images will remain in the Resident's medical record. Sponsor gives permission to have still photographs of the Resident displayed for decorative purposes in the residential area only and not in public waiting areas. Sponsor further gives permission to use audiovisual equipment to record individual, group and family therapy sessions for internal staff training purposes only.

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

11. **EARLY TERMINATION BY THE INSTITUTE/LIQUIDATED DAMAGES.** The Institute reserves the right to terminate this Agreement at any time due to: (i) failure of Sponsor to pay any amounts due under paragraph 4 and (ii) illegal behavior by the Resident. **In the event that The Institute elects to terminate the Resident pursuant to the terms of this paragraph, Sponsor understands and agrees that Sponsor shall immediately (1) pay all outstanding account balances and fees through the discharge date of the Resident.**

    If, during the course of treatment, The Institute, in its sole discretion, determines that the resident's clinical needs can no longer be met through the program delivery system, resulting in the termination from the program, sponsor shall immediately pay all outstanding account balances. The Institute will refund the residual pre-payment moneys. .

12. **SPONSOR EDUCATION PROGRAM AND COOPERATION.** Sponsor agrees to exercise good faith best efforts to attend any seminars for parents and guardians of the residents conducted by The Institute during the Program, and to give Sponsor's full cooperation to The Institute personnel throughout the Program, in order to maximize the benefits of the Program for the Resident and the Sponsor. Sponsor also agrees to read any educational materials and watch any video programs sent to Sponsor by The Institute, and to fill out and return to The Institute any interactive educational materials, while the Resident is in the Program.

13. **ESCORTS.** If an escort is required to bring the Resident to Syracuse, Utah to the Institute, or to return the resident from Utah or for any other transport deemed necessary by The Institute, Sponsor agrees that any escort or escort service used by Sponsor, whether or not Sponsor is referred to the escort by The Institute, is in all respects an independent contractor contracting directly with Sponsor. Sponsor agrees that The Institute bears no responsibility of any kind for any such escort service or the negligence or failure thereof.

14. **HEALTH INSURANCE.** Sponsor warrants that the Resident 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 Resident may suffer or incur during the Program; or take personal financial responsibility for such costs. Whatever deductibles or coverage exclusions may apply in a given case shall be satisfied entirely by Sponsor.

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

16. **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 shutdown 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.

17. **BINDING ARBITRATION.** Any controversy or claim arising out of or relating to this contract, except at The Institute's option the collection of monies owed by Sponsor to The Institute, shall be settled by binding arbitration conducted in the State of California in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction for purposes of executing upon the award.

18. **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 The Institute for all reasonable attorneys' fees and costs incurred by The Institute in connection with those matters concerning which Sponsor has agreed to pay or indemnify The Institute hereunder.

19. **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).

THE INSTITUTE
c/o ASPEN EDUCATION
17777 Center Court Drive
Suite #300
Cerritos, CA 90703

PARENT'S NAME:_____
ADDRESS: _____
_____

20. **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.

21. **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.

22. **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 or affect its terms and provisions.

23. **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.

24. **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.

25. **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.

26. **ACKNOWLEDGMENT/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, The Institute gives no warranties of any kind, express or implied, to either the Sponsor or the Resident 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 The Institute set forth herein.

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

28. RELEASE OF INFORMATION. The parties authorize the release of the Resident's information via E-mail, Internet technology, voicemail or US mail. While every effort will be made to maintain confidentiality, The Institute accepts no responsibility for the mis-transmission that could result in information becoming available to someone other than the intended receiver. The Institute 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.

_____ _____
Sponsor (Father/Guardian) Date

_____ _____
Sponsor (Mother/Guardian) Date

Accepted:

_____ _____
The Aspen Institute for Behavioral Assessment Date
(THE INSTITUTE)

Credit Card Authorization

I hereby give my consent to the aspen Institute to charge my credit card each mouth for services rendered. I understand that if my credit card declines, a late fee of $50.00 may be assessed; it is my responsibility to phone the Institute's business office if a card change is needed. I also understand that tuition due date and tuition charge is outlined in the financial agreement. Please charge my tuition fee each month to the following credit card:

- American Express Card Number: _____ Expiration: _____
- Visa Card Number: _____ Expiration: _____
- Master Card Number: _____ Expiration: _____
-Discover Card Number: _____ Expiration: _____

Exact Billing name and address as shown on the above credit card statement

I also give my consent for the Institute to charge my credit card for charges related to shipping costs of my son/daughter's personal belongings as they are incurred. The charges will also include a $2.00 processing fee per shipment. If I have a different credit card in which to charge this amount, I will note it below, along with the full name of the cardholder, as well as exact billing address;

Card Type & Number: _____ Expiration: _____

By signing below, I understand and agree to the statement relating to charges to my credit card and authorize the Institute to process such transactions relates to my child's confinement.

_____ _____

Signature of Card Holder Date

Patient's Rights and Responsibilities
Advance Directives

Common questions and answers..

What is a Ventilator?
This may also be called a respirator. It is a machine used to maintain or assist with breathing.

Who can make a Living Will?
Any competent person, 18 years or older can make a Living Will. Living Wills are not only for older people, they are helpful for people of all ages.

Do Living Wills include organ and tissue donation?
Living Wills can state your wishes regarding organ donations, including specific organ donations, tissue donations or total body donations.

SPECIAL POWER OF ATTORNEY

What is a Special Power of Attorney?
A written statement giving legal authority to another person to make health care decisions on your behalf. This is used when you are unable to participate in decision making due to injury or illness. This person does not have to be a lawyer, but must be 18 years or older.

May I appoint more than one person for my Special Power of Attorney?
Yes. It is necessary for you to decide the order in which these people will be asked to make decisions for you. Some people appoint someone in addition to their spouse in case they are both in the same accident. Communicate your desires and wishes related to your health care with those appointed.

What is the difference between a Living Will and a Special Power of Attorney?
A Living Will allows you to exercise your legal right to instruct your physicians, family and friends regarding the use of life sustaining and other medical procedures in advance of an injury or illness. A Living Will becomes effective only when you suffer from a terminal condition or a persistent vegetative state.

A Special Power of Attorney allows the people you select to make medical decisions and sign medical consent forms on your behalf. It is more flexible than a Living Will because it allows the people you have chosen to respond to new or unplanned developments in your health care needs. It is not limited to a terminal condition or persistent vegetative state.

Why should I have a Living Will and/or a Special Power of Attorney?
They can help your family and physician by letting them know the kind of medical treatment you want or do not want, if and when you cannot speak for yourself. A Living Will and/or Special Power of Attorney may help you avoid feelings of guilt and family disagreements related to the care you receive.

What do I do with my Living Will and/or Special Power of Attorney Form?

Give a copy of these to your physician(s) and family members and hospital at the time of admission. Share this information with your family and anyone else who may need to know. Be certain that the people you have chosen to have the Special Power of Attorney have a copy. A Living Will should be kept in a secure but accessible place, not in a safe or safe deposit box. Keep them available in case of an emergency.

What if I already have a Living Will and/or Special Power of Attorney from another state; do I need to complete another one?
Yes. Advance directives should be completed for the state in which you live as laws differ from state to state. An advance directive written in another state will be followed unless it is in conflict with the law of the state of Utah.

When do Advance Directives take effect?
Advance directives take effect when you are unable to make health care decisions for yourself.

Can a Living Will or Special Power of Attorney be changed or revoked?
Yes. A Living Will and/ or Special Power of Attorney can be changed or revoked at any time either verbally or in writing. Another person can be named to be the Special Power of Attorney by completing a new form and having it signed by a Notary Public. Each form should be dated; the most recent would be recognized in case of question.

MEDICAL TREATMENT PLAN

What is a Medical Treatment Plan?
A legally binding directive to physicians and providers of medical services that describes medical care and treatment to be provided or withheld. A Medical Treatment Plan is different than a Living Will as it is only written when you have been diagnosed with a serious injury or illness. It should be written by you and your physician according to your wishes.

2

What do I do with the Medical Treatment Plan?
The original of the Medical Treatment Plan should be kept by your physician and a copy should be given to the people with your Special Power of Attorney.

DIRECTIVES BY THE LEGAL GUARDIAN OR RELATIVES

What happens if I do not have an Advanced Directive?
If you are 18 years or older and it has been determined that you have a terminal condition or are in a persistent vegetative state and have not written a Living Will or assigned a Special Power of Attorney, life-sustaining procedures may be withheld or withdrawn under the supervision of your physician according to a written directive by someone who is acting on your behalf. This is usually a legal guardian or relative.

SUMMARY

1. Obtain forms from Aspen Institute, the hospital, senior centers or the Utah Medical Association.

2. Complete the forms with the help of physician(s), family members and friends by following the instructions. Legal advice is not required.

3. Give copies to your physician(s), hospital, family members and the people assigned to your Power of Attorney, if applicable.

Policy of Transferable Physician Order for Life-Sustaining Treatment

Dear Parent/Guardian,

Pursuant to State law, the legal guardian of a minor patient must be informed regarding Transferable Physician Orders in the event the patient is transferred to a medical surgical hospital for live-sustaining treatment. Associated with live-sustaining treatments are advanced directives such as a living will.

You have the option to complete and sign these documents. If so, a copy of these documents will be included in the medical chart of the child.

- ❑ I have been given a copy of advanced directives and related directives on transferable physician order.

- ❑ I have chosen **NOT** to place advanced directives for my child in the medical chart.

- ❑ I have completed the advanced directives and directed the Institute staff to place said directives in the medical chart of my child.

_____

Parent/Guardian Name (print) **Signature** **Date**

_____

Witness (print name) **Signature** **Date**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR SON/DAUGHTER MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about this notice, please contact Dr. Jared Balmer:

WHO WILL FOLLOW THIS NOTICE

This notice describes our facility's practice and that of:

- Any health care professional authorized to enter information into the medical record.
- All employees, staff and other facility personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about the child's health is personal. We are committed to protecting medical information about the minor child. We create a record of the care and services the minor child receives at our facility. We need this record to provide the minor child with quality care and to comply with certain legal requirements. This notice applies to all of the minor child's care generated by the facility. The minor child's personal doctor or other professionals may have difference policies or notices regarding their use and disclosure of medical information created in their office or clinic.

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

We are required by law to:

- make sure that medical information that identifies the minor child is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about the minor child; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT A MINOR CHILD

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

For Treatment: We may use medical information about the minor child to provide medical treatment or services. We may disclose medical information about the minor child to facility personnel who are involved in caring for the minor child while they are in our facility. For example, the milieu staff or kitchen staff may need to know if the minor child is a potential suicide risk so that precautions are taken for the child's safety. Different departments of the facility also may share medical information about the minor child in order to coordinate the different things the child may need, such as prescriptions, lab work, or emergency medical treatment.

For Payment: We may use and disclose medical information about the minor child so that the treatment and services rendered by the facility may be billed to and payment may be collected from you, an insurance company or a third party. For example, we will need to give your health plan clinical updated information about treatment progress of the minor child so your health plan will pay us or reimburse you. We may also tell your health plan about treatment the minor child is going to receive to obtain prior approval or to determine whether your plan will cover the treatment (e.g. psychological testing, if approved by you first.)

For Health Care Operations: We may use and disclose medical information about the minor child for facility operations. For example, we may use medical information to review our treatment and services and to evaluate the performances of our staff in caring for the minor child. We may also combine medical information about facility residents to decide what additional services the facility should offer, what services are not needed, and, whether certain new treatments are effective. We may also disclose information to other facility personnel for review and learning purposes. We may also use information to determine how we are doing and see where we can make improvements in the care and services we offer. We may remove

information that identifies the minor child from this set of medical information so others may use it to study health care and health care delivery without learning who the specific residents are.

Health-Related Benefits and Services: We may use and disclose medical information about the minor child to tell about health-related benefits, or services that may be if interest to you.

Individuals Involved in the Minor Child's Care or Payment for Care: We may release medical information about the minor child to someone who helps pay for care.

Research: Under certain circumstances, we may use and disclose medical information about the minor child for research purposes. For example, a research project may involve comparing outcomes of treatment.

As Required by Law: We will disclose medical information about the minor child when required to do so by federal, state or local law.

Special Situations:

Public Health Risks: We may disclose medical information about the minor child for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a resident has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

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

Law Enforcement: We may release medical information if asked to do so by a law enforcement official;

- In response to a court order, subpoena, warrant, summons or criminal conduct;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain an agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities: We may release medical information about the minor child to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about the minor child to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

YOUR RIGHTS REGARDING MEDICAL INFORMATION OF THE MINOR CHILD (UNTIL LEGAL AGE OF 18 IS REACHED)

You have the following rights regarding medical information we maintain of the minor child;

Rights to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about the minor child's care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about the minor child, you must submit your request, in writing, to the Institute. If you request a copy of the information, we may charge a fee for the costs of copying, mailing and/or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about the minor child 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 the facility.

To request an amendment, your request must be made in writing and submitted to the Institute. 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 the facility;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." To request this list of accounting of disclosures, you must submit your request in writing to the Institute. Your request must state a time period which may not be longer than six years and may not include dates before February 26, 2003. Your request should be indicated 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.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about the minor child for treatment, payment or health care operation. You also have the right to request a limit on the medical information we disclose about the minor child to someone who is involved in the care of the minor child or the payment for the care, like a family member or friend. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide emergency treatment.

To request restrictions, you must make your request in writing to the Institute. 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 to the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Institute. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of the Notice: You have the right to a paper copy of this notice. You may ask us to give you a 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 the notice.

You may obtain copy of this notice at our website, www.aspenassessment.com.

To obtain a paper copy of this notice, call the Institute at (801) 825-5222.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about the minor child as well as any information we receive in the future. We will post a copy of the current notice in the facility. The notice will contain, on the first page, in the top right-hand corner, the effective date. In addition, each time you come to the facility, we will offer you a copy of the current notice in effect.

COMPLAINTS: If you believe the minor child's privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. To file a complaint with the facility, contact Dr. Jared U. Balmer, Executive Director, or Mike Bulloch, Clinical Director at (801) 825-5222. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about the minor child, you may revoke that permission, in writing, at any time. If you revoke your permission we will no longer use or disclose medical information about the minor child for the reasons covered by your written authorization. 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 provide to the minor child.

Insurance Agreement

Patient _____

Account # _____

We, as guarantors/insureds/Parent(s**)** on the above mentioned patient account understand that Aspen Institute for Behavioral Assessment may not be contracted with my insurance provider network(s).

Because Aspen Institute may not be a contracted provider, we have been made aware that some claim payments will be sent directly to the insured.

We understand that we may have been given a financial consideration on this account. We further understand that all insurance carriers are billed at our normal daily per diem rate of $1,000.00 per day.

We agree to immediately forward copies of all insurance explanation of benefit forms and checks from our insurance company explaining the payment information to Aspen Institute within 5 days of receipt of payment or a denial of benefits.

Aspen Institute, will, in turn, determine what additional monies are owed, based on the normal daily per diem rate, and will charge the account, as per the signed financial agreement and credit card authorization on file at Aspen Institute.

Aspen Institute will provide the guarantor with an updated statement for their records at the time charges are made.

Signed: _____ Date: _____

Signed: _____ Date: _____

Please fax all the above paperwork to the Institute upon completion.

With the next set of paperwork, you can either print it off as a PDF, or go onto our website and open and save the Psycho-Social Assessment as a Word Document. You can then either type out the answers and email them to Randi Nelson at rnelson@aspenassessment.com, or fax them along with the formal application. Either way, it is crucial that our admitting therapist and treating doctor have this history prior to admission so they can know your child a bit better upon admission.

PSYCHO-SOCIAL ASSESSMENT

Resident Name:_____ **D.O.B.**_____

Religious Preference: _____ Age:_____ Sex:_____

Presenting Problem(s) Briefly describe the issues/concerns which led to your decision to place your child. Include behaviors, attitudes, emotional status, means of coping, etc., demonstrated by your child over the recent past. _____

_____

_____ _____

_____

_____ _____

_____

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_____

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_____

_____

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_____

_____

_____

Past Treatment/ Intervention History: Please list prior treatment (and response), diagnosis, professionals or other specialized services your child has received including medications.

Facility/Practitioner Name	Location /Phone #	Dates/Frequency Start to End

Family Composition/Environment: Please list names, ages, relationships and other relevant information regarding all immediate family members, whether they are living in or outside of the home. In blended families: Please include child/parent and child/sibling relationships.

Parent & Sibling Name	Sex M/F	Age	Marital Status	How related to Resident	Where Living	Education	Occupation

Comment:

Family Medical/Mental Health History: Please include significant medical problems, psychiatric and/or substance abuse issues of extended family including Grandparents, Uncles, Aunts, and Cousins.

Residents History:

Birth/Neonatal History:

Birthplace_____ Birth-weight_____ Normal Pregnancy □ Complication(s) □

If complications, explain: _____

_____

Parental attitude regarding pregnancy/birth/adoption:

_____

_____

_____

History of Drug/Alcohol use and/or mental health issues/problems during pregnancy?

_____

_____

□ **Adoption**

Circumstances of adoption: include age, birth-parent history, placements

_____

_____

_____

_____

Developmental History: Age walking? _____ Age talking in complete sentences?_____ Age toilet-trained? _____

Please explain if delays occurred:_____

How active as a baby?_____

How difficult was your child as a baby to soothe?_____

_____

What age what your child able to sleep in their own bed?_____

Excessive nightmares?_____

Was your child in daycare?_____

What was your childs response to early separation from a parent?_____

How did they respond to other care providers i.e. nannies, grandparents?_____

_____

Fine motor skill development?

_____

Significant Disturbances during childhood: (including colic, losses, family illness, separation, tantrums, trauma, etc.)

_____

_____

_____

_____

Personality as a child (shy, restless, overactive, withdrawn, outgoing, timid, athletic, etc.)

_____

_____

_____

List any achievements, accomplishments, and what factors may have contributed to such achievements:

_____

_____

_____

_____

Recreation: List favorite recreation/leisure activities, (playing with friends, sports, outdoor, cultural, artistic, activities, etc.), and current recreation/leisure if different. Please note any significant loss of interests or change of focus.

_____

_____

_____

_____

Past/Present Medical History:

Date of last Physical Exam: _____Problem Identified: _____

_____

Date of last Dental Exam_____ Problem Identified: _____

_____

Orthodontia: □ yes □ no If yes, explain any issues The Institute needs to be aware of: _____

_____

Please list past psychotropic medications and responses to such:

_____

_____

Please list current medication, dosage, and observed response(s): _____

_____

Please list current Over the Counter Medications (OTC) and Herbal medication currently taking, including vitamins: _____

_____

Glasses: □ yes □ no Contacts: □ yes □ no Explain any issues The Institute will need to be aware of: _____

_____

Please note issues such as sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood streptococcal infections, food allergies, eating disorders, knee or back injuries, asthma, overly sensitive to sounds, textures, foods, etc._____

_____

_____

_____

Has your child had any physical condition that has been treated with surgery in the past year? ☐ yes ☐ no
If yes, list procedure, physician's name, address, and phone number, and if it is something that needs to be followed up, while at The Institute.

Is there a medical condition that would prevent or limit your child from participating in physical activities (i.e. orthopedic problem, etc.) or may limit his/her activity level? ☐ yes ☐ no
If yes, list limitations and/or concerns:

List any therapies: i.e. physical-speech and/or occupational therapies that need to continue while your child is at the Institute:

Is there any special equipment that you child is currently using, that he/she may need while at The Institute (i.e. crutches, knee braces, walker, retainer for orthodontia, nebulizer [or asthma] etc,) ☐ yes ☐ no
If yes, please explain: _____

Living Environment History: Please describe history of home life, moves, daycare, relationship with parents and siblings, and current home situation

How often does your family have dinner or other meals together?

What chores and responsibility do you assign your child?

Parents: Briefly describe all parents/guardians in terms of personality, marital status, disciplinary systems, parenting style and involvement, how much direct involvement with the child, etc.

Other Significant Relationships: (include peers, adults, relatives, dating, and authority figures).

_____

_____

_____

_____

_____

_____

Education:

Does the student have any diagnosed learning differences? □ yes □ no
If yes, explain including accommodation necessary to address the learning differences:

_____

_____

_____

_____

What was your daughter/son's attendance, achievement and attitude toward school/ education during *Elementary School*? Did bullying occur? Peer relationships (did your child make friends easily)? Difficulties with concentration, attention? Physical illnesses?

_____

_____

_____

_____

What was your son/daughter's attendance, achievement and attitude toward school/education during *High School* ? Did your daughter/son make friends easily?

_____

_____

_____

_____

School last attended: _____ ___ Grade: _____ Comments: _____

_____

_____

_____

_____

Previous school attended: _____ Grade: _____Comments:_____

_____

_____

_____

Does The Institute need to take into account any special needs/accommodations with regard to cultural and religious beliefs? □ yes □ no If yes, please explain:

_____

_____

_____

_____

_____

Employment History: Please list jobs held by your son/daughter, include babysitting, lawn care, etc.

_____

_____

_____

_____

Substance Abuse History: Use of alcohol and/or illicit drugs? □ yes □ no
If yes, please explain: (include what substances, drugs of choice, frequency, how administered, for how long, daily patterns).

_____

_____

_____

_____

_____

Does your child use tobacco? □ yes □ no □ don't know Frequency?_____

Sexual/Relationship History: (Is your son/daughter sexually active, do they have more than one partner**,** use birth control?).

_____

_____

_____

_____

_____

Current relationship with significant other (feelings, sexual, communication, conflicts, parenting, etc.).

_____

_____

_____

_____

What is your childs attitude regarding his/her sexual identity/orientation? What effect(s) does this have?

_____

_____

_____

_____

Has your child ever had episodes of sexual misconduct? □ yes □ no □ don't know
If yes, please explain: _____

_____

_____

_____

Abuse or Neglect: Was your son/daughter ever assaulted or abused physically, sexually, or emotionally? Was resident abused and/or neglected. What is (are) date(s) of alleged abuse/neglect? Was case ever reported to the proper authorities?

_____

_____

_____

_____

_____

Religious/Spiritual/Cultural Influences:

Does your child identify with a religion, spiritual group/church, and/or higher power? ☐ yes ☐ no If yes explain:

_____

_____

_____

_____

Describe resident's/family's upbringing (e.g., church membership, attendance, youth group involvement, etc.)

_____

_____

_____

_____

What is the current involvement if any?

_____

_____

_____

_____

What cultural influences may be important regarding treatment at The Institute?

_____

_____

_____

_____

_____

_____

_____

Legal Involvement: Please list any past or present involvement with the legal system including arrests, probation, community service/education, court diversion programs etc. List any upcoming court dates, probation appointments etc. including name and phone number of a contact person:

_____

_____

_____

_____

_____

Resident's Behavioral Outbursts:

Has your child demonstrated behavioral outbursts? (i.e. swearing, verbal/physical aggression/threats, destruction of property, self harm, etc.)

☐ yes ☐ no If yes, please describe: _____

_____

_____

_____

_____

Are there specific interventions that you have utilized in the past in order to de-escalate such behavior? ☐ yes ☐ no

If yes, please describe: _____

_____

_____

_____

Resident's Strengths/ Weaknesses:

In your opinion, what are your son's/daughter's limitations:_____

_____

_____

_____

_____

In your opinion, what are your son/daughter's strengths:_____

_____

_____

_____

_____

Goals for Treatment: (what are your goals/expectations regarding the focus/outcome of treatment at The Institute)?

_____

_____

_____

_____

_____

_____

_____

Person(s) completing the Psycho-Social Assessment Form:

_____

Print Name(s)	**Signature**	**Relationship to resident**	**Date**

Dear Parent or Guardian,

We are very pleased to provide you an additional way to connect with your child while at Aspen Institute, through the use of *Parent Check In*.

What is Parent Check In?

Parent Check In is a password protected web based site which allows families to keep in touch with their son or daughter's progress by logging onto the site with a password generated by Aspen Institute to view pictures of their child involved in daily life, read summaries of treatment progress completed each month by educators, recreation staff, Team Directors, and Primary Therapists, and keep track of upcoming events, such as school grading, Parent Seminars, staff information, and other information of interest to families.

Why Parent Check In?

The old adage that a "picture is worth a thousand words" is particularly true when you have a son or daughter away from home. Being able to also get another "take" about treatment progress through a review can also add to the weekly contact a family has with the Primary Therapist. Plus additional comments from other staff in direct relation to your child; such as teachers, recreational therapists, and Milieu staff.

Does Aspen Institute have any concerns?

Parent Check In, in no way, is intended to provide a complete, ongoing, report as to how your child is doing. Families that become overly focused on the minutia of a particular report or picture can become prey to the pitfalls of micromanagement. As you review progress notes about your child, you will note that the progress is rarely linear, nor consistent across the landscape of education, therapy, the milieu, and recreational programming. That variability is how change occurs.

What about the attached Parent Check In Release of Information Form?

The Parent Check In program has been in place in several Aspen Education Group Programs for many years now and families surveyed about the program have given it very high marks. Families particularly rated the ability to view pictures of their son or daughter in group activities as most helpful, as those pictures told more about their own child than an isolated, individual shot ever could. They realized that their own child's picture could then be viewed by other families, but gave written permission, so as to have that possibility to view group images. The Release Form states the conditions and limitations under which an image of one family's child can be viewed by another family that has access to the protected website. All families that agree to these conditions to view group pictures also agree to keep the images of other students private. If, for special circumstances, a family does not want to provide a release, Aspen Institute will respect that family's wishes and restrict any sharing of their son's or daughter's pictures with other Aspen Institute families.

When does the information update?

Randi Nelson (rnelson@aspenassessment) maintains the Parent Check In site by setting up accounts, taking individual student pictures, and updating web based report forms. Please contact her if you ever have any questions or concerns with Parent Check In.
She posts new pictures once a month. The notes on your child from the various other staff will be added for you to view.

Anything else?

To get this going for you, we need your Release form as soon as possible. You can fax it, attention: Randi Nelson (801)825-5222, email it (to the address listed above) or mail it in to Aspen Institute.

Thank you ever so much for you support,

Sincerely,

Don Vardell
Executive Director

ASPEN INSTITUTE PARENT CHECK-IN RELEASE OF INFORMATION AUTHORIZATION

On behalf of _____ D.O.B. _____ D.O.A. _____
(Name of Resident) (Date of Birth) (Date of Admit)

I, _____ authorize Aspen Institute
(Name of Parent or Guardian) to post photographic images of my resident, _____ on the Parent Check-In site maintained by Aspen institute. I understand that those images may be viewed by my educational consultant and by other program participants who are authorized and provided a password to access this site. I further understand that images that would be accessed by other program participants would be of group pictures, and that, other information including, but not limited to: name, address, time of admission, etc. would not be included with such images. I further understand that images of _____ that would be able to be
(Name of Resident)
viewed by others authorized to access the Parent Check-In site would be photographic images of groups of individuals and that images depicting single images of residents are only posted for the private viewing of the sponsors of said resident.

I further understand that photographic images I may view on the Parent Check-In site which include other program participants are confidential, and may not be released to other parties without written permission of said participants.

Date: _____ Signed: _____
(Sponsor – parent or legal guardian)

#1. Printed Name: _____

E-Mail Address: _____

#2. Printed Name: _____

E-Mail Address: _____

Resident's Previous Placement: _____

Primary Therapist _____ _____

Referring Professional _____

Do you allow access to your Referring Professional?_____