Outback Therapeutic Expeditions
50 North 200 East
Lehi, UT 84043
Admission (800) 817-1899 | Main Office (801) 766-3933
FAX: (877) 303-8458

Please review and complete all attached material prior to your student's arrival at Outback Therapeutic Expeditions. The following checklist will help ensure that all material and necessities are met. If you have any questions regarding this material please contact an admissions counselor at 800-817-1899.

BEFORE ARRIVAL	
☐ Paperwork	**Application must be completely filled out before child is in the physical custody of Outback Therapeutic Expeditions.** There are two (2) parts to the admissions paperwork: The Application for Admissions and the Supplemental Documents (this packet). 1. The Application a. We prefer you fill out the Application for Admissions online. This is a secure process and available at http://www.outbacktreatment.com/admissions.html b. If you prefer we can e-mail, fax, or mail the paperwork to you and you can fax it to Outback at (877) 303-8458. 2. Supplemental Documents a. All Supplemental Documents enclosed must be completed, signed and faxed to Outback at (877) 303-8458. These include: · Enrollment Agreement · Payment Agreement · Insurance Information Form **with a photocopy of insurance cards** · Communications Consent · Disclosure of Information Form · Parentcheckin.com · Interstate Compact Placement Request
☐ Clinical Approval	Once you have submitted the application (whether online or faxed), we will review the information to ensure that Outback Therapeutic Expeditions is an appropriate placement for your child. This process can be accomplished within 24 hours.
☐ Travel Arrangements	Please arrange travel arrangements as soon as possible. Please keep in mind the following when making these arrangements: 1. Purchase the airline tickets **ONLY AFTER** your child has been accepted into the program. When possible purchase one-way tickets. Keep in mind the average stay at Outback is 6-8 weeks. 2. Students can be admitted into Outback Monday through Friday. Please talk to an admissions counselor for weekend admits. 3. Your child should arrive in Salt Lake City prior to 3:00pm. Please discuss any concerns with this time frame with your admissions counselor. Departure flights should be scheduled **NO EARLIER** than 2:00 pm. See Discharge Information Section for additional departure instructions.
☐ Necessary Items	Outback will provide all clothing and gear necessary during your child's stay. The only items needed from you are: 1. Medications (please send at least a 1 month supply with your child). 2. Prescription Eyewear Glasses are required. Contacts are not appropriate because of dust,

☐ Necessary Items *(cont.)*	smoke, etc. Please send the glasses in a protective case. Talk to your admissions counselor with any concerns. 3. Retainers (with case to keep when not in use) 4. Two (2) disposable cameras All clothing and additional items brought with the student will be stored at the office until the discharge date. Instructions on items needed for discharge will be provided at a later date. See discharge information for more details. **Please leave all items such as jewelry, electronics, cell phones etc... at home**
☐ Payment	Outback works on a daily rate of $465.00 / day with $2000 one time enrollment fee. Payment for the initial 42 days along with the enrollment fee is due upon your student's arrival to Outback. Please complete the Payment Agreement Form (attached) and fax to Outback prior to your student's intake date. Please see the Tuition Calculation table on the Payment Agreement for specific amounts per days enrolled. If you have any questions regarding financing options, please speak with an admissions counselor.
☐ Medications	1. Please completely fill out the medication section (16) of the application including the exact name of the medication, dosage, form and administration time(s). 2. Please send **ALL THE MEDICATION YOU HAVE IN THE ORIGINAL PRESCRIPTION BOTTLES. The medications must be in their original prescription bottles or Outback will not be able to use them- no exceptions**. If you cannot supply at least a 30 day supply, please send what is available and make sure to send the refilled prescription to Outback before the supply is exhausted. Please send the refills to: Outback Therapeutic Expeditions C/O (Your child's name) 50 North 200 East Lehi, UT 84043 If your child requires an inhaler, you must send two (2) inhalers. If your child requires more than one kind of inhaler, please send two (2) of each.
UPON ARRIVAL	
☐ Phone Calls	You will receive a phone call notifying you of your child's safe arrival with an initial report on how he/she is doing. During this conversation you will be asked to contact the therapist directly. If the therapist is unavailable he/she will return your call within 24 hours. During this call you will schedule your weekly update calls, discuss specific expectations and begin the therapeutic process.
☐ Reading Assignment	Please purchase and read the book *Leadership and Self Deception* by the Arbinger Institute. You can purchase this book online at Amazon.com or check with the nearest Barnes and Noble. This short, easy-to-read book will give you additional tools and skills that reflect how we work and interact with the children during their stay with us. We suggest reading this in the next couple of days, before writing the placement letter.
☐ Placement Letter	Be prepared to write a 2-3 page type-written letter to your child that explains your decision to enroll them in Outback. When writing this letter, please keep in mind some of the principles discussed in Leadership and Self Deception. List the specific behaviors that led to your placement decision, and include a brief paragraph at the end of the letter that contains a list of your child's strengths. Your Outback therapist will assist you with the final crafting of the Placement

Placement Letter *(cont.)*	Letter once your child arrives at Outback. Please discuss this project during your first scheduled parent/therapist phone call.
☐ Weekly Letters	Each week you can send letters to your child via FAX (877) 303-8458, or email, mail@outbacktreatment.com. Please send these letters by noon on Friday. The therapists will then take these letters to your child on Monday. Any letters your child may have written to you will be faxed to you on Wednesday, Thursday, or Friday mornings. If you have questions or concerns regarding the letter process, please contact us.
☐ ParentCheckin.com	If you signed up to participate in parentcheckin.com, you will receive an e-mail directing you to your child's website within three (3) business days AFTER your child has arrived in the program. This website is intended to support the communication received from your therapist NOT replace it. Please remember that therapy with your child/family is our focus. This site includes: · A weekly photo from the field · Written updates from the therapist · Additional information on staff and program specifics
☐ Parent Workshop / Visit	In addition to your weekly phone calls, Outback offers a parent workshop seminar you will be asked to attend once during your child's stay. Your assigned therapist will discuss with you the timing of your visit. This workshop consists of a one day seminar, exploring the underlying concepts, strategies, program philosophy and some ideas and skills in working with teenagers. The following morning you will drive out to the field to reunite with your child and participate in a family session. Although it is not required, Outback strongly recommends you attend this workshop. Please discuss the details of the seminar and your visit with your therapist.
☐ Additional Communications	Your therapist is available to you via e-mail. However, because of field time and additional time away from the office, there may be delays in response time. Please be patient as the therapists work on continued communication with all the families they are working with.
DISCHARGE INFORMATION	
☐ Discharge Information	**Flight Arrangements** Because of the logistics in getting your child from the field, showered and ready for transition, your child's departing flight should not be scheduled before 2:00 p.m. MST. **Personal Items** During the first two weeks of your child's stay you will receive specific information regarding what is needed for discharge. Please ensure that you have sent to Outback the necessary clothes and personal items for their transition per the instructions sent to you. **Gear** The gear provided by Outback is the student's to keep. This will be shipped home within 1 week of completing the program. Because of size and weight of this gear, it is shipped UPS ground and can take ten (10) or more days for arrival. **Medications** Medications cannot travel with your child if he or she is going on to a placement unescorted. You will need to make arrangements with the placement to have medications there to meet your child after Outback. Outback will ship all "excess" medications home.

OUTBACK THERAPEUTIC EXPEDITIONS ENROLLMENT AGREEMENT

This agreement ("Agreement") is entered into by and between Outback Therapeutic Expeditions, LLC, a Delaware limited liability company (hereinafter "Outback"), operating Outback, an outdoor adolescent therapy 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 "Program") and the parents(s) and /or guardian(s) of the Student (herein after the "Sponsors") (names). Sponsor's address is and phone is: . In consideration of the mutual promises set forth in this Agreement, Outback 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 Outback 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, Outback 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 Outback, and Sponsor expressly warrants the truth and accuracy of the same.

2. ENROLLMENT OF THE STUDENT. Upon Sponsor's initial payment and completion of this Agreement, the Enrollment Application and all related documentation, and upon Outback's execution of this Agreement, Outback shall accept the Student conditionally for enrollment in the Program, subject to the terms and conditions of this Agreement. Sponsor acknowledges and agrees that Outback's conditional acceptance of the Student is subject to the personal evaluation and screening process conducted by Outback prior to completion of the Assessment phase of the Program. If the Student satisfies Outback's screening criteria, Outback shall accept the Student and, except as otherwise provided herein, permit the Student to complete the Program. If the Student fails to satisfy Outback's screening criteria, the Student will be returned promptly to Sponsor. Outback will refund Sponsor the unused prepaid tuition fee less (1) the pro-rated daily rate through the date of return, (2) a $500 evaluation/screening fee, and (3) a deduction for all reasonable expenses, including gear, incurred by Outback 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 for the student's entire stay (a minimum length of stay is at least 28 days), beginning with the Student's arrival in Salt Lake City, or Lehi, 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 Outback 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 or until the Student attains the age of eighteen (18).

4. PROGRAM COSTS AND PAYMENT TERMS.

A. PROGRAM FEE. The Student is accepted with the expectation that the Student will complete the entire Program. The Program fee is four hundred sixty-five dollars and no cents ($465.00) per day and a nonrefundable Two Thousand Dollar and no cents ($2000.00) enrollment fee.

B. PAYMENT/CANCELLATION REFUNDS The amount of deposit shall be paid by certified check or credit card payable to Outback and delivered to Outback along with Sponsor's submission of this fully executed Enrollment Agreement and must be paid in full on or before the Student's arrival date. Sponsors are liable for the entire Program fees and any other amounts due under this Agreement. Sponsors utilizing insurance shall remain liable for any portion of the Program fee and any other amounts due under this Agreement not paid in full by Sponsor's or Student's insurers. Any unused portion of the student expense fee shall be refunded to Sponsor upon Student's discharge from the Program. A cancellation received less than seven (7) days prior to the arrival date will result in a 50% refund. The amount retained by Outback may, if deemed appropri-

by Outback, be used as credit against any future enrollment of the Student.

C. EARLY WITHDRAWAL OF STUDENT. If Sponsor withdraws Student before expiration of the minimum period of enrollment (28-days) without the recommendations of the Program Director, Sponsor forfeits the remaining balance of the 28-day minimum stay plus a $2000 enrollment fee. Any pre-payments above and beyond the minimum stay will be reimbursed to Sponsor. Student transcripts and other documentation will not be released until all financial obligations have been met.

D. 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, or Lehi, 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.

E. 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 Outback or any third party, and (2) any personal injury to any Outback personnel, other students or third parties caused, in whole or in part, by the Student; and to promptly reimburse Outback for any costs and expenses, including legal fees, it may incur in connection therewith.

F. RUNAWAY EXPENSES. In the event the Student runs away from the Program, Outback 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 Outback 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.

G. LOSS OR DAMAGE TO STUDENT'S PROPERTY. Outback 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.

H. SUBCONTRACTING. Sponsor agrees and consents to Outback's subcontracting certain services to be rendered under this Agreement to persons or entities deemed by Outback to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both parties. Outback 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 Outback. 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.

I. FIRST AID CARE. Outback provides only general first aid care. In the event that the Program staff determines that additional care is needed, the Program will obtain additional medical attention as necessary for the well-being of the Student. Sponsor agrees to pay for all medical care and related costs as stated elsewhere in this agreement, specifically, Paragraph 5.

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 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 Outback 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, Outback and Aspen Education Group (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 Outback to: (a) provide emergency first aid to the Student in the field and enroute 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 Outback'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 Outback to arrange for a physical examination (including a drug screen urine/blood test, at Outback's option) and any psychological assessments of the Student deemed necessary by Outback 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 Outback, to release all information regarding the Student's medical and/or psychological history, diagnoses and treatments to Outback upon request. Outback 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 Outback personnel to search the person and personal effects of the Student at any time, including a "strip search." In connection with such search, Outback 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. Outback is further authorized to confiscate any and all items deemed by Outback to be contraband or counterproductive to the Student's successful completion of the Program. The disposition of all items confiscated by Outback shall be left to the sole discretion of Outback.

8. AUTHORIZATION FOR RESTRAINT. Sponsor hereby authorizes Outback personnel to physically restrain, control and detain the Student by the exercise of necessary passive restraints when deemed necessary by Outback, 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 Outback arrive, at which time Outback 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. PHOTOGRAPHIC/AUDIO RECORDING AUTHORIZATION. Sponsor hereby authorizes Outback to take and utilize the name, voice, photographs and/or videotapes or audiotapes of the Student during the Program, without any compensation to Sponsor or the Student. Sponsor understands and agrees that these photographs and tapes of Student's acts, poses, plays, faces, person, likeness and appearance of any and all kinds and/or recording of voices (with the right to "dub" the voice of another in place of Student's) may be used in preparing promotional literature or publicity and tapes for Outback in any medium, together with instrumental, musical, and other sound effects provided by Outback. Sponsor waives his or her and Student's rights of publicity in connection therewith.

10. RESEARCH AUTHORIZATION. Sponsor hereby authorizes Outback 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.

11. EARLY TERMINATION BY OUTBACK/LIQUIDATED DAMAGES.

A. TERMINATION BY OUTBACK. Outback 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 unknown physical, medical, mental, or emotional problem(s) of the Student; or (iv) for any other reason if Outback deems it necessary for the protection of the Student, any other student(s) or the integrity of Outback's Program. In the event of any such termination by Outback after the Student has been accepted into the Program , neither Sponsor nor Student's insurer shall be entitled to a refund of any part of the Program fee or tuition. However, in the sole discretion of Outback, except in the case of termination under paragraph 11A(i) above, the Student may participate in a subsequent Program if the condition(s) that led to the Student's prior termination has been resolved to Outback's satisfaction, with a credit, to be determined by Outback in its sole discretion, against the Program fee for prior Program fee payments.

B. WITHDRAWAL BY SPONSOR. In the event Sponsor or any authorized third party, after the Student's arrival date, withdraws the Student for any reason prior to the end of the 28-day minimum stay, neither Sponsor nor the Student's insurer shall be entitled to a refund of any part of the first 28 days of the Program. However, in the sole discretion of Outback, the Student may participate in a subsequent program if the condition(s) that led to the Student's prior withdrawal has been resolved to Outback's satisfaction, with some appropriate credit, to be determined by Outback in its sole discretion, for prior Program fee payments.

C. LIQUIDATED DAMAGES. Outback's entitlement to and retention of the entire Program fee payable under this Agreement in the event of an early termination or withdrawal is not considered by either of the Parties to be a penalty for early withdrawal of the Student. Because of Outback's fixed costs, the impossibility of filling the Student's position once the Program is underway, and the difficulty of estimating and recovering Outback's losses caused by the Student's early termination or withdrawal, the Parties agree that this nonrefundable Program fee policy constitutes a fair and reasonable estimate of Outback's losses (i.e., liquidated damages) associated with any early termination or withdrawal of the Student from the Program.

12. SPONSOR EDUCATION PROGRAM AND COOPERATION. Sponsor agrees to attend the seminar for parents and guardians of the students conducted by Outback at the end of the Program, and to give Sponsor's full cooperation to Outback 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 Outback, and to fill out and return to Outback any interactive educational materials, while the Student is in the Program.

13. 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 Outback, is in all respects an independent contractor contracting directly with Sponsor. Sponsor agrees that Outback bears no responsibility of any kind for any such escort service or the negligence or failure thereof.

14. 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.

15. 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.

16. DELAYED PERFORMANCE. Except for the obligation to make payments when due here un- der, 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.

17. 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 Outback for all reasonable attorneys' fees and costs incurred by Outback in connection with those matters concerning which Sponsor has agreed to pay or indemnify Outback hereunder, including without limitation the provisions of paragraphs 1, 4, 5, 6, 7, 8, 11, 12, 13, 14, and 28 herein.

18. 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):

Outback
C/O Aspen Education Group
17777 Center Court Drive, Suite 300
Cerritos, CA 90703

Parent's Name:

Address:

19. 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.

20. 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.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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, Outback 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 Outback set forth herein.

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

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

Outback Date

Outback Therapeutic Expeditions
50 North 200 East
Lehi, UT 84043
Admission (800) 817-1899 | Main Office (801) 766-3933
FAX: (877) 303-8458

Payment Agreement

TUITION INFORMATION

Tuition applies to every day your child is the responsibility of Outback

1. Count the total number of days he/she will be in the program and include the anticipated admission and graduation day.
2. Multiply total number of days by the tuition amount of $465.00 per day, add enrollment fee of $2000.00, plus a physical examination fee ($167.00 for males/ $182.00 for females), and a gear shipment fee of $50.00

Total Days Enrolled	Amount Due Male	Amount Due Female
42	$21,747	$21,762
49	$25,002	$25,017
56	$28,257	$28,272

METHOD OF PAYMENT

Payment of initial 42 days is due upon enrollment, as well as a $2000 one time enrollment fee, physical examination fee and a $50 shipment of gear fee. Upon completion of the initial 42 day period a monthly billing is done at the beginning of the month and any tuition due beyond the 42 days is due the first day of the extension period.

Your outstanding balance must be paid in full before the completion of the program.

Outback is unable to directly bill insurance companies and therefore requires parents to assume this responsibility independent of tuition payment. Upon completion of your child's stay at Outback, and payment in full, you may request a therapeutic breakdown of costs for you to turn in to your Insurance Company for reimbursement purposes. Outback does not guarantee reimbursement for expenses related to your child's stay.

FINANCIALLY RESPONSIBLE PARTY (Regardless of method of payment)

Printed Name:_____ Signature:_____

Please select at Least one Method of Payment (These are the only forms of payment accepted.)

☐ **Credit Card (Please complete regardless of payment method)**

Visa / Master Card / American Express Number:_____ Exp:___/____
Name as it appears on the card:_____
Signature of Cardholder:_____ Date:_____

☐ **Certified Check:** (Accepted for initial payment only. Extension period payments may not be made via check.)Please write the certified check number:
Send payment overnight mail to: Outback Therapeutic Expeditions (AR), 50 N. 200 E., Lehi, UT 84043

☐ **Wire Transfer (please attach confirmation)**
*Please call Erin Peeples (801-766-3933) for more information.

☐ **Financing Options:**
Available financing options through Clark Behavioral Health Financing. You can contact them at 1-888-755-3080, or begin and online application at http://www.aegprograms.com/financialaid.asp.

MEDICAL INSURANCE INFORMATION

STUDENT'S NAME: _____ Date of Birth: ____/____/ _____

Primary Insurance

Name of Insured: _____

Phone: (_____) _____ Date of Birth: ____/____/ _____

Social Security Number: _____

Insurance Company: _____

Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Group Number: _____

Subscriber ID #: _____

In the case that Outback needs to arrange for refills of the student's prescriptions please enclose a copy of the current insurance card(s) to help us serve you better. We will do our best to process the prescription under your insurance, but please understand that some insurance companies do not contract with pharmacies in Utah. You will remain fully liable for any amounts not paid by your insurance.

_____ _____

Signature of the Policy Holder Date

Prescription Drug Coverage

Name of Company: _____

RX Bin: _____ RX PCN: _____ RX Group: _____

ID# _____ Card holder name: _____

Address: _____City: _____State: _____ Zip: _____

Please attach a photocopy of the student's medical insurance card(s) (Both front and back of card)

FRONT	BACK

Outback Therapeutic Expeditions
50 North 200 East
Lehi, UT 84043
Admission (800) 817-1899 | Main Office (801) 766-3933
FAX: (877) 303-8458

Communications Consent

I authorize Outback Therapeutic Expeditions to transmit personal communication to me by email and/or facsimile.

Please use the following email and/or fax number (If same for both parents, just list once):

MOTHER: (_____) _____ EMAIL: _____

Check one of the following:

- ☐ Secure: The above fax is secure, please fax without notification.
- ☐ Not Secure: The above fax is NOT SECURE, please contact me at the following number prior to any transmission:
  (_____) _____

FATHER: (_____) _____ EMAIL: _____

Check one of the following:

- ☐ Secure: The above fax is secure, please fax without notification.
- ☐ Not Secure: The above fax is NOT SECURE, please contact me at the following number prior to any transmission:
  (_____) _____

Transmission Errors

I understand that errors sometimes occur in the transmission of personal communications between children and parents. I release Outback Therapeutic Expeditions from any and all liability for errors in the transmission of personal communications between my child and myself.

I agree to keep confidential the nature of any communication that I may receive in error and to notify Outback immediately.

Signature: _____ Date: _____

Signature: _____ Date: _____

Outback Therapeutic Expeditions
50 North 200 East
Lehi, UT 84043
Admission (800) 817-1899 | Main Office (801) 766-3933
FAX: (877) 303-8458

Disclosure of Information

The completion of this document authorized 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.

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

Student Name: _____

Persons / Organization authorized to use or disclose the information:
OUTBACK THERAPEUTIC EXPEDITIONS

Persons/Organizations authorized to send or receive the information (Please give name, address, phone and fax numbers of Educational Consultants, Clinical Professionals, Transport Agencies, and Therapeutic Schools and Programs that will be involved with you and your child during his/her stay at Outback Therapeutic Expeditions):

NAME	NAME
ADDRESS	ADDRESS
CITY / STATE / ZIP	CITY / STATE / ZIP
PHONE / FAX	PHONE / FAX
NAME	NAME
ADDRESS	ADDRESS
CITY / STATE / ZIP	CITY / STATE / ZIP
PHONE / FAX	PHONE / FAX

This Authorization applies to the following information (Please Check):

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

[Optional] Except: _____

Signature: _____ Date: _____

Relationship to student: _____

Outback Therapeutic Expeditions
50 North 200 East
Lehi, UT 84043
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FAX: (877) 303-8458

ParentCheckin.com

Outback Therapeutic Expeditions is pleased to provide you with the ability to view updates regarding your child through parentcheckin.com. With a user name and password you will be able to see additional information regarding your child's experience at outback.
If you would like to see a demo of what parentcheckin.com offers you, please go to:

http://www.parentcheckin.com
Username: jj3304
Password: outback

Instructions

Within three business days of admissions, you will receive an e-mail with your unique user name and password. Please keep this on file for future reference.

Outback will update information on your student one day each week.

You may look at this site as often as you wish until 30 days after your student completes the program, at which time the record will be removed.

If Outback takes a picture of my child and another student from his/her group, I release Outback Therapeutic Expeditions from all liability during my child's stay when student group photos are posted on other family's ParentCheckin sites. (I understand that my child's peers may appear with him/her on my site.) Initial ____

Please take the time to fill out our survey regarding this service as you use it. We hope to learn what you like and what suggestions you may have to improve this service.

☐ Yes, I would like to access the Outback ParentCheckin site to enjoy additional updates and information about my child's progress at Outback.

My e-mail address is: _____

☐ Yes, I would like _____, the educational consultant / Therapist I'm working with to have access to my child's site.

☐ No, I would not like to take advantage of the Outback ParentCheckin.

Signature of Parent/Guardian: _____ Date: _____

Outback Therapeutic Expeditions
50 North 200 East
Lehi, UT 84043
Admissions (800) 817-1899 | Main Office (801) 766-3933
FAX: (877) 303-8458

Psychological Testing (Recommended but Optional)

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 / compulsive disorders, and sleep disorders. Assess personality functioning. Obtain data regarding developmental and emotional age. Obtain data regarding family dynamics. Evaluates who the child is and why he or she is behaving as they are.

Behavioral: Screen for substance abuse. Screen for trauma and abuse. Screen for risk or 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 they are accepting students for whom they can be most helpful. Consequently, testing is often an important component of treatment and aftercare planning.

If you are interested in receiving a Psychological evaluation for your son or daughter, please discuss this with your assigned therapist during your weekly phone conversation. **These tests are given at an additional fee – billed through Psychological Testing Services**. The therapist will arrange with you all necessary information to complete the testing in a timely manner, based on when it will be most appropriate for your child.

Outback Therapeutic Expeditions
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Lehi, UT 84043
Admissions (800) 817-1899 | Main Office (801) 766-3933
FAX: (877) 303-8458

Interstate Compact – Instructions

The interstate compact on the placement of children was developed in the 1950's to ensure protection and services to children who are placed across state lines. The Compact is a uniform law that has been enacted by all fifty states. It establishes orderly procedures for the interstate placement of children and fixes responsibilities for those involved in placing the child. The basic intent of the law is to protect children, parents and placement facilities from the possibilities of being abandoned or placed out of state with no support of funding in place.

Beginning in July of 1996, Utah decided to comply with the basic intent of the law in such a way that will be the least intrusive and inconvenient to you as a parent / guardian.

Please complete Section I of the form with your information. All sections to be completed by the parent or guardian are marked with *. The form must also be signed in Section III under the **signature of sending person**. FAX the form with your Outback Therapeutic Expeditions Enrollment Agreement. Outback will then get the information to the appropriate compact administrator.

ICPC 100A
REV. 8/2001

One form per child
Please type

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

TO: **FROM:**

SECTION I - IDENTIFYING DATA

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

Hispanic Origin: ◯ Yes ◯ No ◯ Unknown ◯ Cannot Determine

Social Security Number: - -

ICWA Eligible ◯ Yes ◯ No

Ethnicity: ◯ American Indian or Alaskan Native ◯ Black or African American ◯ Asian ◯ White ◯ Unknown ◯ Cannot Determine ◯ Native Hawaiian/ Other Pacific Islander

Sex: ◯ Male ◯ Female

Date of Birth

Title IV-E determination ◯ Yes ◯ No ◯ Pending

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:
OUTBACK THERAPEUTIC EXPEDITIONS

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

Address: 50 N. 200 E. LEHI, UT 84043

Phone: 801-766-3933

Type of Care Requested:

◯ Foster Family Home
◯ Group Home Care
◯ Child Caring Institution
◯ Residential Treatment Center
◯ Institutional Care-Article VI, Adjudicated Delinquent
◯ Parent
◯ Relative (Not Parent) Relationship:
● Other OUTDOOR TREATMENT PROGRAM

☐ 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:
OUTBACK THERAPEUTIC EXPEDITIONS 50 N. 200 E. LEHI, UT 84043

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

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:

DISTRIBUTION (Complete six (6) copies):

- Sending Agency retains a (1) copy and forwards completed original plus four (4) copies to:
- Sending Compact Administrator, DCA, or alternate retains a (1) copy and forwards completed original and three (3) copies to:
- Receiving Agency Compact Administrator, DCA, or alternate who indicates action (Secion IV) and forwards a (1) copy to receiving agency and the completed original and one (1) copy to sending Compact Administrator, DCA, or alternate within 30 days.
- Sending Compact Administrator, DCA, or alternate retains a completed copy and forwards the completed original to the sending agency.

NOTICE OF PRIVACY PRACTICES
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 Outback Therapeutic Expeditions

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 HIPM, 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 not 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;
. 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 information for underwriting premium rating or other health insurance-related activities
. 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 Jaw.
. 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

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.

YOU'RE 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 wit h 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 c affiliated entities. Our Notice of Privacy Practices provides information about how we may use and disclose your pro 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 th1 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 EDUCATION GROUP

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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 Education Group
Persons/Organizations authorized to receive the information:_____
Purpose of requested use or disclosure: 2.At the request of the individual

_____

This Authorization applies to the following information (select only one of the following):
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 one year from admission date.

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:

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

Neither treatment, payment, enrolment or 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 1onger be protected by federal confidentiality law (HIP M). 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 m~ or unless such disclosure is specifically required or permitted by law.

I may inspect 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 M, 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 M 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.

Omnicare

Patient Admission Record and Agreement

Facility Name: _____ **Admission Date:** _____ **Pharmacy Name:** _____

PATIENT INFORMATION

Room # _____ **Bed** _____

First Name_____ Last Name_____ MI_____

SSN#_____ DOB_____ Sex [ ] M [ ] F Medicare (HICN)#_____

Physician's Name _____ Phone Number (_____)_____

Patient is solely responsible for the financial and legal authorizations: YES [ ] NO [ ] **If NO, please list the Legal Representative below:**

First Name_____ Last Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____ Home Phone_____

A Legal Representative is a person who has been granted the authority in writing by either the Patient or a court of law to make medical and/or financial decisions on behalf of the patient.

PRIMARY CONTACT and FINANCIALLY RESPONSIBLE PARTY INFORMATION

First Name_____ Last Name_____ Relationship to Patient_____

Address_____ City _____ State_____ Zip_____ Home Phone (____)_____

Primary Contact is also Financially Responsible Party YES [ ] NO [ ] **If NO, please list Financially Responsible Party below:**

First Name_____ Last Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____ Home Phone_____

A Financially Responsible Party is a person, other than the Patient, who agrees to be responsible for payment of all charges for products and services provided to the Patient.

PAYMENT SOURCE FOR PHARMACY PRODUCTS AND SERVICES

To assist in billing for medications and services provided to the patient while at this facility, please check all that apply:

Admitting Pay Source: MEDICARE-A [ ] MEDICARE-D [ ] SELF [ ] MEDICAID [ ] INSURANCE [ ] MEDICARE ADVANTAGE [ ] HOSPICE [ ] VETERAN [ ] or OTHER_____ ***Please describe "other" and provide pharmacy with copies (FRONT and BACK) of ALL Drug Coverage cards.***

Authorization for Invoice Payments by the following methods:

Credit Card [ ] Visa/MC/Discover/AmEx Card#_____ Exp_____ Security Code _____

Bank Account Transfer [ ] Acct#_____ Routing#_____ Bank_____ City _____ State___ Zip_____

Omnicare

Patient Name _____

Patient Admission Record and Agreement

Facility _____

By signing below, the Patient or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the following terms:

1. **Authorizations:** Omnicare, Inc. and its subsidiaries ("Omnicare") are authorized to provide the Patient all products and services prescribed or ordered by the Patient's Physician or by the facility. The Patient requests the products provided by Omnicare be dispensed in containers that are not child resistant. The Patient requests that the facility and/or Omnicare dispose of, or otherwise process, all unused and/or discontinued medications dispensed to the patient, according to facility and pharmacy policy as allowed by professional standards and regulations.
2. **Legal Representative:** Legal Representatives will provide Omnicare with documentation establishing their legal authority.
3. **Assignment of Benefits:** The Patient or Legal Representative hereby requests and authorizes any third-party payer to make payment directly to Omnicare for products and services provided to the Patient.
4. **Payment:** The Patient and Financially Responsible Party are responsible for paying all charges for products and services provided to the Patient by Omnicare. As a courtesy, Omnicare will submit claims to any insurance companies or other third-party payers listed above or of which Omnicare is subsequently notified in writing; however, the Patient and Financially Responsible Party are ultimately responsible for paying any charges not covered by insurance or another third party payer. Payment in full is due within 30 days of the invoice date, and a finance charge equal to the lesser of 1.5% per month or the maximum rate permitted by law will accrue on all delinquent accounts beginning on the day after the payment is due. The Patient or their Legal Representative and/or the Financially Responsible Party hereby authorize Omnicare to charge any credit card or bank account number identified above for any amounts owed.
5. **Fees and Expenses:** The Patient and Financially Responsible Party are responsible for paying all costs and expenses incurred by Omnicare in the collection of amounts owed and the enforcement of its rights under this agreement, including without limitation, attorney's fees, court costs and expenses.
6. **Assurance of Payment; Termination of Services:** The Patient or Legal Representative and Financially Responsible Party acknowledge that if the Patient and Financially Responsible Party are delinquent on payment of any amount owed to Omnicare, Omnicare may, in its sole discretion, do either or both of the following: (a) condition its continued provision of products and services to the Patient upon Omnicare's receipt of assurance of payment acceptable to Omnicare, which may include, without limitation, a requirement that Omnicare receive authorization to charge all amounts owed, past and future, to a valid credit card number; and/or (b) suspend or terminate its provision of products and services to the Patient. Such suspension or termination will in no way affect the Patient's or Financially Responsible Party's obligations to pay all amounts owed under this agreement, including costs of collection.
7. **Reliance and Consideration.** Omnicare is relying upon the Financially Responsible Party's agreements herein in determining to provide products and services to the Patient, and Omnicare's provision of products and services to the Patient constitutes good and adequate consideration for Financially Responsible Party's agreements contained in this agreement.
8. **Disclosure or Use of Patient Information for Treatment, Payment, and Healthcare Operations.** The Patient or Legal Representative hereby authorizes Omnicare, its employees, agents and sub-contractors to disclose to the Medicare or Medicaid program or to any other third party payer any medical or other information needed for payment for all products and services provided by Omnicare to the Patient until payment has been made in full. The Patient or Legal Representative further authorizes Omnicare, its employees, agents and sub-contractors to use and disclose the Patient's medical and other information for the provision of products and services, for the business operations of Omnicare and for the review of Omnicare's services, including review by accrediting bodies or governmental agencies.
9. **Modification:** No modification or amendment of this agreement shall be effective unless agreed to in writing by Omnicare.

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Patient/Legal Representative Name	Signature	Date
Financially Responsible Party Name	Signature	Date

NOTE: If patient **has personally signed,** it is not necessary to complete the information below. If the patient is **unable to sign**, an authorized Representative may sign on his/her behalf, but must complete all information, including the patient's medical reason for an inability to sign.

Authorized Representative's Relationship to Patient	Street Address	City, State and Zip Code	Medical Reason for Patient's Inability to Sign

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 FOR DISCUSSION AND RELEASE OF PROTECTED HEALTH INFORMATION

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: _____

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: _____

□ 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.