



In addition to the Sage Walk the Wilderness School application, we **require the following information along with the remainder of this paperwork and the Enrollment Agreement 24 hours prior to admission:**

- Completed Initialed and Signed Enrollment Contract \* If you live outside of the State of Oregon, you will need to complete the Interstate Compact for the Placement of Children (DHS forms 100A and 100B included in the contract). **Please fill out the first sections of each page with the child and family information and then sign each page as the "Sending agency or person supplying information"**
- Individual Education Plan (if applicable)
- Copy of a current Immunization records.
- Copy of Child's health Insurance card (both sides enlarged & lightened if possible)
- Copy of the parent Drivers License (both sides enlarged & lightened if possible)
- Child Custody Papers (if applicable)
- A 30-Day supply of Medication(s) the student is currently taking
- Eye Glasses with hard case (if applicable, contacts are not allowed)

**\*\*A Physical health examination will be administered upon arrival at SageWalk\*\***

If you have concerns regarding your child's ability to pass the required physical exam, you may have one done by your physician before admittance. However, it is a SageWalk requirement to have one performed and approved upon arrival, in addition to the one your physician has completed.

All information needs to be faxed to 541-316-4810 or emailed to [sarahc@sagewalk.com](mailto:sarahc@sagewalk.com)

Any questions pertaining to these requirements or the remainder of the application can be directed to one of our Admissions Counselors at 800-877-1922.

Thank You!

**Wilderness Therapy Programs Inc. dba SageWalk the Wilderness School**  
**1116 SW Obsidian Ave, Redmond, OR 97756**  
**800-877-1922**  
**800-877-1923 Fax 541-316-4810**  
**PROGRAM ENROLLMENT CONTRACT**  
**(WTP)**

This agreement ("Agreement") is entered into by and between WTP SageWalk the Wilderness School, (hereinafter "WTP"), operating SageWalk the Wilderness School, 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 "Program") and \_\_\_\_\_ **parent(s)** and /or guardian(s) of the Student (hereinafter the "Sponsors"). Sponsor's address is: \_\_\_\_\_ and phone is: \_\_\_\_\_.

In consideration of the mutual promises set forth in this Agreement, WTP 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: \_\_\_\_\_ (full and preferred name), whose birth date is \_\_\_\_\_ (hereinafter the "Student"), and that Sponsor desires to and does hereby contract with WTP 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, WTP 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 WTP, and Sponsor expressly warrants the truth and accuracy of the same.

**2. ENROLLMENT OF THE STUDENT.** Upon Sponsor's initial payment as set forth in Exhibit "A", and completion of this Agreement, the Enrollment Application and all related documentation, and upon WTP's execution of this Agreement, WTP shall accept the Student conditionally for enrollment in the Program, subject to the terms and conditions of this Agreement. Sponsor acknowledges and agrees that WTP's conditional acceptance of the Student is subject to the personal evaluation and screening process conducted by WTP prior to completion of the Assessment phase of the Program. If the Student satisfies WTP's screening criteria, WTP shall accept the Student and, except as otherwise provided herein, permit the Student to complete the Program. If the Student fails to satisfy WTP's screening criteria, the Student will be returned promptly to Sponsor and a deduction for all reasonable expenses incurred by WTP 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 a minimum of \_\_\_\_\_ days beginning with the Student's arrival, now anticipated to be \_\_\_\_\_ (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 WTP 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), unless the Student (a) has otherwise been placed in the custody of WTP 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 (18<sup>th</sup>) birthday.

**4. PROGRAM COSTS AND PAYMENT TERMS.**

- A. **PROGRAM FEE.** The student is accepted with the expectation that the Student will complete the entire Program. Unless otherwise set forth in Exhibit "A", the program fee is **\$465.00 a day**, plus a **\$2,000.00** Enrollment/Gear Fee, with a recommended psychological testing fee of **\$2,400.00**. Please note that all students graduated on Wednesday, which will affect the total of days in the program and the overall cost. Also note that the Psychological Testing is required to partake in the reenrollment guarantee.
- B. **SCHEDULE AND METHOD OF PAYMENT OF PROGRAM FEES; LATE FEES; EXTENSIONS.**
  - (1) At the time of admission, private pay sponsors shall pay the full initial amount of the student's scheduled stay plus the enrollment fee.
  - (2) This initial payment may be paid by check. All subsequent payments, if any, shall be paid only by accepted credit card (VISA, MasterCard or American Express), or personal check.

Legal Section

- (3) Sponsor shall also provide a valid credit card number with available credit at the time of admission. In the event that any fees, costs or subsequent extensions, including but not limited to the initial physical cost, medication costs, outfitting costs and additional medical expenses, are not paid when due. Sponsor authorizes the program to charge these items, including late fees, to this credit card number.
- (4) With the exception of the discharge summary, student files and records will not be released after a student discharges until all tuition and fees are paid in full.
- (5) Students with student loans must provide a copy of an executed promissory note from the lending institution at the time of admission. Actual funding must take place within five days of enrollment. Students receiving school district assistance must pay tuition and fees when due. The program will refund Sponsor upon receipt of payment from the school district.
- (6) Any extension must be agreed upon by staff and Sponsor prior to its commencement. Payment for an extension must be paid in advance for the full length of the additional stay. Failure to pay within the first week of the extended period could result in immediate student discharge.
- C. EMERGENCY ADMISSION EXCEPTION. Upon written approval by the program, the Sponsor of a student who is admitted within 48 hours of the initial call shall pay a deposit of a minimum of 10 days and sign an enrollment agreement. This deposit must be secured by a third party, such as a credit card, wire transfer, ACH transfer or cashier's check. Personal checks are not acceptable for deposits. Full payment for the program's minimum length of stay must be received no later than seven days of admission. If payment for the remainder of the agreed upon minimum length of stay has not been received within seven days of admission, the student will be discharged prior to 10 days.
- D. PAYMENT/CANCELLATION REFUNDS. A cancellation received less than seven (7) days prior to the arrival date will result in a 50% refund. The amount retained by WTP may, if deemed appropriate by WTP, be used as credit against any future enrollment of the Student.
- E. EARLY WITHDRAWAL OF STUDENT. If Sponsor withdraws Student before expiration of the minimum period of enrollment without the specific recommendations of the Clinical Director, Sponsor forfeits the remaining balance of the minimum stay. Any pre-payments above and beyond the minimum stay will be reimbursed to Sponsor.
- F. ADDITIONAL COSTS AND EXPENSES. In addition to the Program fee, Sponsor agrees to pay for the following expenses of the Student: transportation from the Student's current residence to Program, 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 list. Sponsors are also responsible for any additional escort fees required for transporting Student to and/or from the Program to another location (i.e. airport, doctor's appointment or special event). Sponsors are responsible for the cost of any psychiatric evaluations performed by a psychiatrist or Psychological testing performed by a contracted Psychologist.
- G. PERSONAL INJURY AND DAMAGE TO PROPERTY. Sponsor agrees to accept full responsibility for (1) the repair or replacement of any property damaged, defaced, or destroyed by the Student, whether owned, leased, or controlled by WTP or any third party, and (2) any personal injury to any WTP personnel, other students or third parties caused, in whole or in part, by the Student; and to promptly reimburse WTP for any costs and expenses, including legal fees, it may incur in connection therewith.
- H. RUNAWAY EXPENSES. In the event the Student runs away from the Program, WTP 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 WTP 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.

Legal Section

- I. **LOSS OR DAMAGE TO STUDENT'S PROPERTY.** WTP is not liable for any loss of or damage to any of the Student's property. The Student is fully responsible for the same at all times.
- J. **SUBCONTRACTING.** Sponsor agrees and consents to WTP's subcontracting certain services to be rendered under this Agreement to persons or entities deemed by WTP to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both parties. WTP 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 WTP. The Student is under the care and supervision of his/her attending clinician and it is the responsibility of the Student's clinician to obtain the Sponsor's informed consent, when required, for medical, surgical, or psychiatric treatment, special diagnostic or therapeutic procedures, or other services rendered the Student under the general and special instructions of the clinician.
- K. **NURSING CARE.** WTP provides only general nursing care unless, upon orders of the Student's physician, the Student is provided more intensive nursing care. If the Student's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the Sponsors. WTP shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that Student is not provided with such additional care.

**5. ASSUMPTION OF RISKS, RELEASES AND INDEMNITIES.** Sponsor acknowledges serious hazards and dangers, known and unknown, inherent in the Program, including but not limited to: ranch, agricultural and vocational activities, emotional and physical injuries, illness or death that may arise from strenuous hiking, climbing and camping in a natural environment, exposure to the elements, plants and animals, running away from the Program, "acts of God" (nature), the ropes course, kayaking, water sports, stress, involvement with other students, self-inflicted injuries, and transportation to and from the Program's field location(s). Sponsor understands that in participating in the Program, the 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 Program with knowledge of the dangers involved and agree to accept any and all risks.

In consideration for being permitted to participate in the Program, Sponsor agrees to not sue, to assume all risks and to release, hold harmless and indemnify WTP 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. and Aspen Health Services Corporation (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 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 Student 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. 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 Program. 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.

Legal Section

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 Program. 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." □ Aspen Education Group, Wilderness Therapy Programs SageWalk the Wilderness School, 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:**

\_\_\_\_\_  
Parent

\_\_\_\_\_  
SW Rep

**6. AUTHORIZATION FOR MEDICAL CARE AND RECORDS.** In the event of an accident, injury, illness, or other medical necessity, Sponsor hereby authorizes WTP 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 WTP'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 WTP to arrange for a physical examination (including a drug screen urine/blood test, at WTP's option) and any psychological assessments of the Student deemed necessary by WTP 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 WTP, to release all information regarding the Student's medical and/or psychological history, diagnoses and treatments to WTP upon request. WTP shall handle all such protected health information (also "PHI") pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act ("HIPAA") Act of 1996.

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

**8. AUTHORIZATION FOR RESTRAINT.** Sponsor hereby authorizes WTP personnel to physically restrain, control and detain the Student by the exercise of necessary restraints when deemed necessary by WTP, 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 WTP arrive, at which time WTP personnel may re-obtain custody or control of the Student or authorize continued custody by the law enforcement agency until travel is arranged for the Student's return home.

**9. RESEARCH AUTHORIZATION.** Sponsor hereby authorizes WTP 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.

Legal Section

**10. EARLY TERMINATION BY WTP/LIQUIDATED DAMAGES.** WTP 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 WTP deems it necessary for the protection of the Student, any other student(s) or the integrity of WTP's Program. **In the event that WTP elects to terminate the Student pursuant to the terms of this paragraph, Sponsor understands and agrees that Sponsor forfeits all monies pre-paid to the program.** The forfeiture reflects the recognition that certain costs associated with making the program available to the Student are incurred, whether or not the program is completed, including such items as salaries, inventories, and other general operating expenses. Therefore, Sponsor understands and agrees that the policy of non-refundable payments and expenses is a reasonable estimate of the losses (i.e., Liquidated Damages) the program incurs with the early termination of Student.

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

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

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

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

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

**16. ATTORNEY'S FEES.** In the event that either party is found in default or material breach of any specific promise, term or condition expressly set forth in this Agreement by an arbitrator(s) or a court of competent jurisdiction, said party shall be liable to pay all reasonable attorneys' fee's, 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 WTP for all reasonable attorneys' fees and costs incurred by WTP in connection with those matters concerning which Sponsor has agreed to pay or indemnify WTP herein.

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

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

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

Legal Section





**RELEASE OF INFORMATION**

(May be duplicated if necessary)

Student: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Phone: \_\_\_\_\_

I/we authorize WTP SageWalk the Wilderness School to release any and all information to the referral source listed on this application and all Aspen Education Group (AEG) Programs. I/We authorize the below named educational consultants, professionals and/or institutions to release and receive all information concerning the above named student to and from WTP SageWalk the Wilderness School and all AEG Programs.

Information should include as much of the following as would be helpful in providing additional assessment and continuation care: medical/treatment history, psychological evaluations, discharge summaries, progress case notes and/or academic records.

**Referral Source**

**Insurance Company**

\_\_\_\_\_  
Name/Title  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City State Zip  
\_\_\_\_\_  
Phone/Fax  
\_\_\_\_\_  
/\_\_\_\_\_  
Inclusive Dates of Treatment

\_\_\_\_\_  
Name/Title  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City State Zip  
\_\_\_\_\_  
Phone/Fax  
\_\_\_\_\_  
Policy Number

**Agency / Institution**

**Agency / Institution**

\_\_\_\_\_  
Name/Title  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City State Zip  
\_\_\_\_\_  
Phone/Fax  
\_\_\_\_\_  
/\_\_\_\_\_  
Inclusive Dates of Treatment

\_\_\_\_\_  
Name/Title  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City State Zip  
\_\_\_\_\_  
Phone/Fax  
\_\_\_\_\_  
/\_\_\_\_\_  
Inclusive Dates of Treatment

\_\_\_\_\_  
Parent/Guardian Signature Date



**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.

Legal Section



# Interstate Compact on the Placement of Children Report on Child's Placement Status

One form per child

TO: \_\_\_\_\_

FROM: \_\_\_\_\_

## SECTION I -

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

## SECTION II - PLACEMENT STATUS

- Initial Placement of Child in Receiving State      Date Child Placed in Receiving State: \_\_\_\_\_  
     Name of Resource: \_\_\_\_\_  
     Address: \_\_\_\_\_  
     Type of Care: \_\_\_\_\_
- Placement Change      Effective Date of Change: \_\_\_\_\_  
     Name of Resource: \_\_\_\_\_  
     Address: \_\_\_\_\_  
     Type of Care: \_\_\_\_\_

## SECTION III - COMPACT PLACEMENT TERMINATION

- Adoption Finalized       In Sending State       In Receiving State       Court Order Attached
  - Child Reached Majority/Legally Emancipated
  - Legal Custody Returned to Parent(s)      Court Order Attached
  - Legal Custody Given to Relative      Court Order Attached  
     Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
  - Treatment Completed
  - Sending State's Jurisdiction Terminated with the Concurrence of the Receiving State
  - Unilateral Termination
  - Child Returned to Sending State
  - Child Has Moved to another State
  - Proposed Placement Requested Withdrawn  
     Name of Placement Resource: \_\_\_\_\_
  - Approved Resource Will Not Be Used For Placement  
     Name of Approved Placement: \_\_\_\_\_
  - Other (Specify): \_\_\_\_\_
- Date of Termination: \_\_\_\_\_

## SECTION IV - SIGNATURES

Signature of Person/Agency Supplying Information: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Compact Administrator, Deputy or Alternate: \_\_\_\_\_ Date: \_\_\_\_\_

DISTRIBUTION (Complete four (4) copies):

- Sending Agency retains a (1) copy and forwards completed original plus three (3) copies to: CF 100b (10/01) PC 10/01
- Sending Compact Administrator, DCA, or alternate retains a (1) copy and forwards two (2) completed copies to:
- Receiving Agency Compact Administrator, DCA, or alternate retains a (1) copy and forwards a (1) copy to the receiving agency.



# Interstate Compact on The Placement of Children Request

One form per child

**TO:**

**FROM:**

**SECTION I - IDENTIFYING DATA**

Notice is given of intent to place - Name of Child :		Ethnicity Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Determine/Unknown	
Social Security Number:	ICWA Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White	
Sex:	Date of Birth:	Title IV-E Determination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	
Name of Mother		Name of Father:	
Name of Agency or Person Responsible for Planning for Child:			Phone:
Address:			
Name of Agency of Person Financially Responsible for Child:			Phone:
Address:			

**SECTION II - PLACEMENT INFORMATION**

Name of Person(s) or Facility Child is to be placed with:		Soc Sec # (Optional): Soc Sec # (Optional):	
Address:			Phone:
Type of Care Requested:		Relationship:	<input type="checkbox"/> ADOPTION <input type="checkbox"/> IV-E Subsidy <input type="checkbox"/> Non IV-E Subsidy <b>To Be Finalized in:</b> <input type="checkbox"/> Sending State <input type="checkbox"/> Receiving State
<input type="checkbox"/> Foster Family Home <input type="checkbox"/> Group Home Care <input type="checkbox"/> Child-Caring Institution	<input type="checkbox"/> Residential Treatment Center <input type="checkbox"/> Institutional Care-Article VI, <input type="checkbox"/> Adjudicated Delinquent	<input type="checkbox"/> Parent <input type="checkbox"/> Relative (Not Parent) <input type="checkbox"/> Other: _____	

**Current Legal Status:**

<input type="checkbox"/> Sending Agency Custody/Guardianship	<input type="checkbox"/> Protective Supervision
<input type="checkbox"/> Parent Relative Custody/Guardianship	<input type="checkbox"/> Parental Rights Terminated-Right to Place for Adoption
<input type="checkbox"/> Court Jurisdiction Only	<input type="checkbox"/> Unaccompanied Refugee Minor
	<input type="checkbox"/> Other:

**SECTION III - SERVICES REQUESTED**

Initial Report Requested (if applicable)	Supervisory Services Requested	Supervisory Reports Requested
<input type="checkbox"/> Parent Home Study	<input type="checkbox"/> Request Receiving State to Arrange Supervision	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Relative Home Study	<input type="checkbox"/> Another Agency Agreed to Supervise	<input type="checkbox"/> Semi-Annually
<input type="checkbox"/> Adoptive Home Study	<input type="checkbox"/> Sending Agency to Supervise	<input type="checkbox"/> Upon Request
<input type="checkbox"/> Foster Home Study		<input type="checkbox"/> Other:

Name and Address of Supervising Agency in Receiving State:

**Enclosed:**

<input type="checkbox"/> Child's Social History	<input type="checkbox"/> Court Order	<input type="checkbox"/> Financial/Medical Plan	<input type="checkbox"/> Other Enclosures
<input type="checkbox"/> Home Study of Placement Resources	<input type="checkbox"/> ICWA Enclosure	<input type="checkbox"/> IV-E Eligibility Document	

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: \_\_\_\_\_

Policy Ref: I-B.3.4.2 CF 100A (10/01) PC 10/01

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 (Section IV) and forwards a (1) copy to receiving agency and the completed original and 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.

**Parent Admission Information**

WTP SageWalk the Wilderness School will be responsible for contacting parents or legal guardian with admission information upon your child’s date of arrival. This contact will include information regarding frequency of service plan contact and the scheduling of an initial appointment.

Parents agree to be responsible for being available to be contacted by their WTP therapist at scheduled appointment times for service plan contact calls. Service plan contact will cover information relating to your child’s care, including, but not limited to their psychological, developmental, educational and medical needs.

WTP SageWalk the Wilderness School is not a religious based organization and is committed to respecting the backgrounds and traditions of our clients and families. Parents agree to inform WTP of any special requirements prior to admission.

WTP SageWalk the Wilderness School offers face-to-face interviews with parents and/or child if convenient to the parents and so requested, prior to the child’s admission.

Parents agree to participate in scheduled weekly service plan meetings, to complete therapeutic assignments, and if your child is completing the reunification track there is also a two-day family workshop prior to discharge.

WTP SageWalk the Wilderness School will make aftercare recommendations to parents or legal guardians prior to program completion during service plan contacts. A written record of recommendations will be forwarded after completion in a reasonable period of time.

I understand the above specified admissions information and acknowledge that I have discussed this with my admissions counselor.

PARENT/GUARDIAN NAME: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

PARTICIPANT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**  
**OF**  
**ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES**

**Effective Date: April 14, 2003**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Human Resources Manager.

**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 30 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 B attached to this Notice. Under the privacy standards contained in HIPAA, legally separate but affiliated entities may designate themselves as a single covered entity for compliance purposes. Accordingly, this Notice constitutes notice of the privacy practices for all of the Aspen-affiliated entities, sites and locations that are listed on the attached Exhibit B, 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; and
- Follow the terms of this Notice that are currently in effect.

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

**USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BY ASPEN THAT DO NOT REQUIRE YOUR AUTHORIZATION**

Aspen uses and discloses protected health information in a number of ways connected to the provision of health care treatment and services, payment for care,

and our health care operations. Some examples of how we may use or disclose your health information without your authorization are listed below.

**We may use or disclose your protected health information without your authorization as follows connected to the provision of health care treatment and services:**

- To physicians, nurses, and others involved in your health care or preventive health care.
- To other health care providers treating you such as hospitals, pharmacies, labs, emergency room staff and specialists. For example, if you are being treated for an injured knee, we may share your health information among your primary physician, the knee specialist, and your physical therapist so they can provide proper care.

**We may use or disclose your protected health information without your authorization as follows in relation to payment for care:**

- To administer your health benefits policy or contract (for Aspen Education Group Employee Benefit Plan members).
- To bill you for health care we provide.
- To pay others who provided care to you.
- To other organizations and providers for payment activities unless disclosure is prohibited by law.

**We may use or disclose your protected health information without your authorization as follows in relation to health care operations:**

- To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we may use your health information to review and improve the quality of care you receive, to provide training, and to evaluate the performance of our staff in caring for you.

Legal Section

- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your health information with other organizations for this purpose, they must agree to protect your privacy.)

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

- As required by law -- When we are required to do so by federal, state or local law.
- Public health and safety -- To an authorized public health authority or individual for public health and safety purposes, including to:
  - Protect or prevent a serious threat to the health and safety of the public or of another person.
  - Prevent or control disease, injury, or disability.
  - Report vital statistics such as births or deaths.
  - Report reactions to medications or problems with products and notify people of recalls of products they may be using. (Food and Drug Administration.)
  - Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
  - Notify an employer concerning work-related injuries or illnesses or workplace medical surveillance in situations where the employer has a duty under federal or state law to keep records on or act on such information.
- Abuse or neglect -- To the appropriate government authority authorized to receive reports regarding abuse, neglect, or domestic violence. We will only make
  - this disclosure if you agree or when required or authorized by law. However, no consent is required in cases involving child abuse or neglect.
- Health oversight activities -- To health oversight agencies for certain activities such as audits, investigations, inspections and licensure.
- Lawsuits and disputes -- In the course of any legal proceeding, in response to an order of a court or administrative agency. Also, in certain cases, in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- Law enforcement -- To law enforcement officials in limited circumstances for law enforcement purposes. For example disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.
- Military activity and national security -- To the military (if you are a member of the armed forces), and to authorized federal officials for national security and intelligence purposes or in connection with providing protective services to the president of the United States.
- Workers' compensation -- Where authorized by law in order to comply with the workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

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

- Facility directory information -- Unless you object, we may use and disclose your name, the location at which you are receiving care, your general condition (e.g., fair, stable, etc.), and your religious affiliation in our facility directory. All of this information except religious affiliation will be disclosed to people who ask for you by name. Members of the clergy (such as a priest or rabbi) will be told your religious affiliation if they ask (but they don't have to ask for you by name). This is to help your family, friends, and clergy visit you in the facility and generally know how you are doing.
- Family and friends -- Unless you object, we may disclose health information about you to a family member, relative, a close friend - or any other person you identify who is directly involved in your health care - who is involved in your care or who helps pay for your care. If you are either not present or unable to make a health care decision for yourself and we determine that disclosure is in your best interest, we may also disclose such health information about you to those persons. For example, we may disclose health information to a friend who brings you into an emergency room.
- Appointment reminders -- To remind you that you have a health care appointment with us. These reminders may be made by postcard, phone, or voicemail unless you specifically ask us to communicate with you through a different method as described later in this Notice.
- Treatment alternatives and health-related services -- To communicate with you about treatment services, options, or alternatives, as well as health-related benefits or services that may be of interest to you.
- Employer group health plans -- For Aspen Education Group Employee Benefit Plan members, we may communicate with your employer for certain administrative activities.
- Health insurance underwriting -- For Aspen Education Group Employee Benefit Plan members, we may use your health information for underwriting, premium rating or other health insurance-related activities
- Research - For research purposes provided that certain steps are taken to protect your privacy. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the facility
- De-identify information -- To "de-identify" information by removing information from your health information that could be used to identify you.
- Disaster relief -- To an authorized public or private entity for disaster relief purposes. For example, we might disclose your health information to help notify family members of your location or general condition.
- Coroners, funeral directors, and organ donation -- To coroners, funeral directors, and organ donation organizations as authorized by law.
- Correctional institution -- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official for certain purposes, such as (1) providing health care to you by the institution; (2) protecting your health and safety or the health and safety of others; or (3) protecting the safety and security of the correctional institution.

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

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

Legal Section

## YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the right to:

- **Restrictions on use or disclosure** -- Request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Please note that we are not required to agree to your request. If we do agree, we will honor your limits unless it is an emergency situation. To request restrictions, you must make your request in writing to the Aspen Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- **Confidential Communications** -- Request that we communicate with you about health matters by another means or at another location. For example, if you want us to communicate with you at a different address we can usually accommodate that request. Any request must be made in writing to the Aspen Privacy Officer. Your request must specify how or where you wish to be contacted. We will agree to reasonable requests.
- **Inspect and copy** -- Inspect and copy health information that may be used to make decisions about your care. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Aspen Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. In certain situations we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.
- **Amend** -- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Aspen. To request an amendment, your request must be made in writing and submitted to the Aspen Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for Aspen;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

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

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

**Paper copy** -- Request a paper copy of this Notice at any time.

Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

## CHANGES TO PRIVACY PRACTICES

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

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

## QUESTIONS

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

Legal Section

**EXHIBIT B-Aspen Entities**

1. Academy at Swift River, Cumington, MA
2. Academy of the Sierras, Reedley, CA
3. Adirondack Leadership Expedition, Saranac Lake, NY
4. Aspen Achievement Academy, Loa, UT
5. Aspen Ranch, Loa, UT
6. Bromley Brook School, Manchester Center, VT
7. Camp Wellspring, NY
8. Cedars Academy, Bridgeville, DE
9. Copper Canyon Academy, Rimrock, AZ
10. Excel Academy, Conroe, TX
11. Healthy Living Academy, Reedley, CA
12. Island View, Syracuse, UT
13. Lone Star Expeditions, TX
14. Mount Bachelor Academy, Prineville, OR
15. New Leaf Academy, Bend, OR
16. New Leaf Academy of North Carolina, Hendersonville, NC
17. Northstar Center, Bend, OR
18. Oakley School, Oakley, UT
19. Outback Therapeutic Expeditions
20. Passages to Recovery, Loa UT
21. Rossier Park Elementary, Orange, CA
22. Rossier Park Junior Senior School, Buena Park, CA
23. SageWalk The Wilderness School, Redmond, OR
24. Stone Mountain School, Black Mountain, NC
25. Sunhawk Academy, St George, UT
26. SUWS of Carolinas
27. SUWS Adolescents & Youth Programs, Shoshone, ID
28. Talisman Summer Camp
29. Turn About Ranch, Escalante, UT
30. Wellspring Camps, Cerritos, CA
31. Youth Care, Inc.

Legal Section

**ACKNOWLEDGEMENT OF RECEIPT**

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

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

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

Signature: \_\_\_\_\_  
(individual/parent/conservator/guardian)

Date: \_\_\_\_\_

**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: \_\_\_\_\_

## Parent Extranet

### Information For Family

WTP Programs is pleased to provide you with the ability to view updates regarding your child. The name of this service is the WTP Parent Extranet. With a user name and password you will be able to see the latest information available from the program. As long as you complete this form and the enrollment agreement that was included in your application or contract, you may take advantage of this service.

**If you would like to see a demo, go to**  
**<http://www.sagewalk.com>**  
**User Name: SageWalk demo**  
**Password: SageWalk**

### Instructions

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

WTP will update information on your student once each week.

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

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 WTP Parent Extranet to enjoy additional updates and information about my child's progress at WTP. (If Yes, go to next paragraph.)  
My email address is: \_\_\_\_\_.
- If you take a picture of my child and another student from his/her group, I don't mind if you upload that picture to the other family's site. (I understand that my child's peers may appear with him/her on my site.)
- Yes, I would like \_\_\_\_\_, the educational consultant I'm working with to have access to my child's site.
- No, I would not like to take advantage of the WTP Parent Extranet.

✍ \_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_ Date

Legal Section

**INFORMATION DISCLOSURE AND CONFIDENTIAL COMMUNICATION**

In the state of Oregon, the Department of Self-Governing Agencies, and Bureau of Occupational Licenses regulate the practice of both licensed and unlicensed persons in the field of psychotherapy under title 54, chapter 34. Licensure of an individual under this chapter does not imply endorsement by the counseling board nor effectiveness of treatment.

You as a client are entitled to receive information about the methods of therapy, techniques used, duration of treatment, fee structure, and information regarding relevant education and training of the WTP staff. This information is found in the WTP application materials and/or can be provided by a WTP admissions counselor or field supervisor. In addition, you are responsible for choosing the WTP program and its treatment modality, and have the right to refuse treatment at any time by withdrawal from the WTP program.

In the state of Oregon, information provided by and to a client during treatment is legally confidential and will not be shared outside the Aspen Education Group system without expressed permission. Exceptions to confidentiality include (1) Suspicion of child abuse/neglect; (2) Any situation in which there is a reasonable possibility that an individual may harm himself/herself or another person; and (3) Situations in which a court orders disclosure.

*After your child graduates from our program, a representative of WTP may follow up by telephone to complete a questionnaire about your child, how he/she is functioning after his/her completion of our program. These questions are designed to provide us with helpful information and to improve the quality of the services we offer. Your signature constitutes a release of information that will allow WTP or its authorized representative to follow up with you regarding your child and the effectiveness of our program. Your participation in this study will be most appreciated.*

I understand client rights/confidentiality as outlined in the Oregon statute. I understand that I may, at any time, request further information regarding these rights.

\_\_\_\_\_  
Signature of Father/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Mother/Guardian

\_\_\_\_\_  
Date

## SAFETY PROVISIONS & PARENT AUTHORIZATION & CONSENT

In as much as I have enrolled my son/daughter (full name) \_\_\_\_\_ in the WTP SageWalk the Wilderness School Adolescent Program beginning (date) \_\_\_\_\_ until graduation, and understanding that the program to be conducted in Oregon is a rigorous physical and emotional experience for youth, and realizing that WTP has exclusive control of (full name) \_\_\_\_\_ during this time, I approve and consent to the following safety procedures to ensure the well-being of all participants:

- Should a parent, legal guardian, or a child have a grievance, they should be encouraged to speak directly with the Executive Director to resolve the grievance. Any issues that a client believes have not been satisfactorily addressed can be directed to the director of the program. In the event that this issue cannot be resolved please contact Sue Crowell, Vice President of the Aspen Education Wilderness Division, at 888-828-9770
- That WTP personnel have my permission to review, return, or restrict all incoming/outgoing mail to/from my child.
- That all medical personnel of any hospital or other appropriate medical facility shall have authorization to provide emergency medical treatment according to their professional discretion during the course of the expedition.
- That any and all psychologists, medical doctors, hospitals, counselors, therapists, or others who have counseled or treated my/our child, and whose names have been provided to WTP on the Parent Concern Questionnaire, are hereby authorized to release all information regarding medical history, diagnosis, treatment, or disability to WTP staff and consultants who will be involved in my/our child's program.
- Should our son/daughter run away from the control and supervision of the WTP staff during the term of the WTP program, all appropriate law enforcement or security personnel of any federal, state, county, or municipal entity shall be directed to detail and retain custody of my/our son/daughter until my spouse or I or any WTP personnel are contacted, at which time WTP personnel may re-obtain custody or control of him/her, or they may authorize continued custody by the entity until travel is arranged for his/her immediate return to my/our home.
- That WTP personnel shall be able to physically restrain, control, and detain my/our child for the following purposes:
  - a) To prevent from running away from WTP supervision, jeopardizing his/her safety and that of other students.
  - b) To detain him/her if for any reason he/she leaves the group and attempts to return home through any means of transportation. This detention shall be for a period of time until WTP personnel have made telephone contact with me or my spouse, at which time a decision will be made to continue the expedition or return him/her home immediately.
  - c) To prevent him/her from hurting or jeopardizing the safety of anyone in the program.
- It is understood that any physical restraint will be the minimum required and will only be used to ensure his/her safety.

Printed Name -- Mother	Signature -- Mother	Date
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Full Address of Mother	City	State	Zip	Phone Number
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Printed Name -- Father	Signature -- Father	Date
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Full Address of Father	City	State	Zip	Phone Number
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\_\_\_\_\_  
Initial

**STUDENT EMERGENCY - SUMMARY INFORMATION**

**STUDENT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
Physical Description: Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Eyes: \_\_\_\_\_ Hair: \_\_\_\_\_  
Identifying Feature(s): \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Waist: \_\_\_\_\_ Shirt Size: \_\_\_\_\_

**Please List Any MEDICATIONS that your Child is CURRENTLY taking and bringing or indicate NONE.**  
*All Medication "MUST" include a Prescription & be in the correct Containers. All medications (including Vitamins & Acne Creams) must include clear doctor's prescriptions, or they will not be dispensed. If you have been given verbal directions to change dosage or time of administration, we must receive a signed and dated fax from the prescribing doctor with the current orders.*

<u>Medication</u>	<u>Dosage/Amount</u>	<u>Sending</u>	<u>AM/PM</u>	<u>Date Prescribed</u>	<u>Reason Taking Medication</u>

Please List any previously experienced medication reactions/side effects: \_\_\_\_\_  
Does your child have a history of refusing to take medication? If so, please list what reactions or side effects might occur: \_\_\_\_\_  
Please list any major illness or physical injury that was suffered by your child previously: \_\_\_\_\_  
\_\_\_\_\_

**Please List Any ALLERGIES, SPECIAL MEDICAL CONDITIONS OR DIETARY CONCERNS that affect your Child, including reactions to Poison Ivy, Latex, Insect Bites, or Shellfish:**  
Allergy/Condition \_\_\_\_\_ Specify Reactions & History \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Vegetarian: Yes** \_\_\_ **No** \_\_\_  
**Does your Child Require the Following:** (Please Circle Appropriate Answer?)  
Prescription Eyewear            Yes            No            Glasses are required, please send a hard case.  
Dental Retainer                Yes            No            Please Send Container  
**Please List Any Additional Information that is NECESSARY for your Child's Care:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Contact Information:**  
Father: \_\_\_\_\_ Mother: \_\_\_\_\_  
Hm Ph: \_\_\_\_\_ Hm Ph: \_\_\_\_\_  
Wk Ph: \_\_\_\_\_ Wk Ph: \_\_\_\_\_  
Cell Ph: \_\_\_\_\_ CellPh: \_\_\_\_\_  
Educational Consultant Name: \_\_\_\_\_ Ph: \_\_\_\_\_

**Arrival Information-** flying or driving  
Airline: \_\_\_\_\_ Flight: \_\_\_\_\_ Arrival Time: \_\_\_\_\_  
Escort: \_\_\_\_\_ Color of carry-on bag: \_\_\_\_\_  
City of last leg of flight arriving from/ or meeting place (driving): \_\_\_\_\_

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: \_\_\_\_\_

Persons/Organizations authorized to receive the information: \_\_\_\_\_

Purpose of requested use or disclosure: \_\_\_\_\_

\_\_\_\_\_

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 [insert date or event]: \_\_\_\_\_

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, 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 (HIP AA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

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

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

Medical Section

\_\_\_\_\_  
Initial

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: \_\_\_\_\_

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

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

MEDICAL INSURANCE INFORMATION

Medical insurance information (to be used as necessary). If your child is covered by Medicaid in a state other than Oregon, medical expenses are not covered. WTP is unable to directly bill insurance companies and therefore requires parents to assume this responsibility independent of tuition payment. However, you will receive a statement of all expenses related to your child's WTP placement.

Student Name (please print) \_\_\_\_\_ Date of Birth \_\_\_\_\_
Student's Social Security # \_\_\_\_\_ Relationship to Subscriber \_\_\_\_\_
Name of Subscriber \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_
Primary Ins. Carrier \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Group # \_\_\_\_\_ Subscriber ID # \_\_\_\_\_
Employer \_\_\_\_\_

Prescription Drug Coverage Information

We will do our best to process the prescription(s) through your insurance, but please understand that some insurance companies do not contract with all pharmacies. You are fully liable for any balance not paid by your insurance. The pharmacy WTP uses will not process prescriptions through your insurance without a copy of both sides of your insurance card.

Please check your insurance card carefully for separate prescription ID number.

Student Name (please print) \_\_\_\_\_ Date of Birth \_\_\_\_\_
Student's Social Security # \_\_\_\_\_ Relationship to Subscriber \_\_\_\_\_
Name of Subscriber \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_
Name of Ins. Carrier \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Group # \_\_\_\_\_ Subscriber ID # \_\_\_\_\_

\* \* \* \* \*

We require that you submit a credit card number to cover the initial physical, medication(s), and any other medical expenses.

I authorize WTP SageWalk the Wilderness School to use my credit card for any medical services that are incurred for the duration of the program. I understand a WTP SageWalk the Wilderness School representative will notify me of any charges billed to my credit card.

Visa/Master Card Number
Expires \_\_\_\_\_

Grid for credit card number: 16 empty boxes

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I declare that the above information is complete and correct.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Initial \_\_\_\_\_

**Marshall Medical Group, LLC Immediate Health Care Clinics**

**Automatic Credit/Debit Card Payment Authorization Transaction Agreement  
Wilderness Program Patient Authorization**

Date	Parents Signature	Wilderness Program

I authorize Marshall Medical Group, LLC (Redmond Immediate Health Care, Lincoln City Immediate Health Care or McMinnville Immediate Health Care) to automatically charge to my credit/debit card my medical care as specified below:

The credit card indicated on this form will be charged for all initial entry physicals into the Wilderness Program and subsequent provider visits either at camp or when transported to one of our facilities, charges will be billed to my card on the date of service.

This Authorization will remain in effect until termination of the Wilderness Program or end of the contract period.

I authorize Marshall Medical to charge my:

-                      

Debit Card \_\_\_\_\_

				-					-					-				
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**Card Expiration:**

		/		
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I understand and agree to this pre-authorized financial arrangement and understand that the billing office will automatically charge my credit card/debit card in accordance to the terms we have agreed to above. I further understand that, should I default on this agreement due to denial of the credit card by my credit card company, or NSF on my debit card, my account will be referred to a collection agency and I will be responsible for a **\$ 100.00** collection fee on top of charges incurred.

\_\_\_\_\_ **Parent Signature,**  
**Date** \_\_\_\_\_

**INTERNAL CONTROL NUMBER # A**