SPRING RIDGE ACADEMY
Enrollment Agreement

SPRING RIDGE ACADEMY, INC. an Arizona Corporation (hereinafter "SRA"), _____ and _____(hereinafter "Sponsor(s)"), _____ (hereinafter the "Student"), whose Date of Birth is_____, and Social Security number is_____

This Enrollment Agreement, by and between SRA and the Sponsor(s) is made under the following agreements. The Sponsor(s) hereby agree that SRA and its staff operate in behalf of, and as agents for, the Sponsor(s).

The Sponsor(s) affirm they are the legal Guardian(s) of the Student. Sponsor(s) expressly desire to contract for enrollment of the Student in Spring Ridge Academy. This Enrollment Agreement is for a **minimum** period of fifteen months, beginning _____. The SRA program requires a minimum fifteen-month commitment from the Sponsor(s) and the Student in order to gain maximum effectiveness (refer to item #11 in financial agreement – terminating student's enrollment). I/We understand that the SRA program includes four (4) phases and each student will complete the program at the pace that is unique to her needs. I/We also understand that each phase builds upon the internalization of the previous phase. I/We understand that the program may, therefore; exceed fifteen months for this student. This agreement is automatically renewed on a month-to-month basis if the Student remains in SRA past fifteen months.

I/We understand that the services offered by SRA are physically and emotionally challenging. Sponsor(s) give their consent for the Student to participate in all aspects and activities of SRA. Activities may include, but are not limited to: Academic classes, academic counseling, therapy, experiential seminars, rigorous exercise, hiking, swimming, sporting games, activities off and on grounds, work projects, transportation, and intervention when deemed necessary. I/We also understand that these activities, as well as any other elements of SRA's programming, may involve a degree of risk to all participants.

I/We now hereby release and discharge SRA, its agents, employees, and officers, from any and all claims, demands, actions, judgments, and executions, except in the case of gross negligence, which the undersigned may have against SRA for all personal injuries known or unknown, and damage to property, personal or real, caused by or arising out of Sponsor(s) and/or Student's participation in the SRA program. I/We understand and agree that enrollment in Spring Ridge Academy and all activities relating thereto are governed by the laws of the State of Arizona and are under the jurisdiction of the courts of Arizona.

I/We understand and agree that the Student's personal effects and also her person may be searched at the discretion of the treatment staff for the purpose of revealing any prescribed or non-prescribed drugs or medications or any other substances or items that are not permitted. All prescribed medications that are to be taken by the applicant will be held in the possession of, and dispensed by SRA personnel. I/We understand and agree that should the Student runaway from the control and

supervision of SRA staff during the term of the SRA program, SRA will use reasonable efforts to assist the Sponsor(s) in finding the Student and in obtaining her safe return. All appropriate law enforcement or security personnel of any federal, state, county, or municipal entity shall be directed to detail and retain custody of the Student until the Sponsor(s) or any SRA personnel are contacted, at which time SRA personnel may re-obtain custody or control of her.

Sponsor(s) hereby give consent and authorization for SRA personnel to physically restrain, control and detain the Student for the following purposes: to prevent the Student from jeopardizing her safety or the safety of others.

Sponsor(s) understands that Spring Ridge Academy is a family systems program and that we require at least one Sponsor to participate in the Parent Challenge and the Family Trainings all of which are key elements of the program.

SRA reserves the right to terminate the enrollment of any Student at any time if there is a default in the performance of any of the terms of this Agreement by the Sponsor(s), or if in the sole discretion of SRA, Student is not a suitable resident of the school, or for any other reason SRA determines that the Student should not continue to reside at the school. This would include, but is not limited to, Sponsor(s) who are unwilling to follow the guidelines of SRA, or are, at the sole discretion of SRA, unreasonable or difficult to work with. In the event a Student's enrollment is involuntarily terminated, SRA shall arrange, at Sponsor(s)'s expense, to transport the Student back to Sponsor(s) address.

Sponsor(s) understands and agrees that SRA cannot guarantee the success or outcome of any student enrolled at Spring Ridge Academy.

Sponsor(s) hereby acknowledge that they have read the entire Enrollment Agreement and that they understand and agree to its provisions. This agreement may be modified or amended if the amendment is made in writing and is signed by both parties.

Date	Signature Mother/Guardian
Date	Signature Father/Guardian
Date	Signature SRA Representative

SPRING RIDGE ACADEMY
Financial Agreement

Student Name_____ Date of Birth_____

REGULAR TUITION AND FEES:

I/We the undersigned agree to pay Spring Ridge Academy upon admission for the following:

First Months Tuition	$6,000.00
Last Months Tuition	$6,000.00
Enrollment Fee (Non-Refundable)	$1,500.00
Student Expense Deposit	$250.00
Student Monthly Allowance	$50.00
Total Due upon Enrollment	**$13,800.00**

The second month tuition will be prorated to reflect the actual number of days enrolled in the first month. All subsequent monthly tuition fees ($6,000.00) are due on the 1st day of each month. All monthly fees are payable in advance. The monthly tuition fee covers the cost of room and board, academic classes, regularly scheduled seminars, and therapy as SRA determines. In the event that collection of any past due accounts is necessary, accrued costs of collection will be added to the account balance.

ADDITIONAL COSTS TO REGULAR PROGRAM:

Student Expenses:

A deposit of $250.00 is charged upon admission for student expenses. This deposit will be used to pay for the following charges as they are incurred:

- Transportation: includes non-urgent or recurrent medical trips ($25 per trip); special needs or activities other than regular program transportation ($25 per trip); transportation to Phoenix or Flagstaff ($100 per trip)
- Shuttle: transportation via shuttles to/from Phoenix Sky Harbor Airport
- Class Fees: The Sponsor(s) understand additional fees may be charged for supplies needed for elective classes (i.e. art, expressive movement, etc.)
- Allowance: $50 per month to be deposited in your daughter's personal "checking" account. The monies will be used for clothing, hair styling, postage, school supplies, student outings and field trips. This "personal" checking account is part of the life skills taught at Spring Ridge Academy. At no time is the student allowance account to be in excess of $250.00. Any overages will be returned.
- Additional financial responsibilities may include costs to repair and/or replace property damaged by a student and/or for any costs incurred should a student require one on-one- supervision longer than 48 hours.

The Student Expense Account must be maintained at $250 during the student's stay at Spring Ridge Academy by monthly detailed billing in addition to the tuition billing and payable upon receipt to the SRA Student Fund. The unused portion will be reimbursed to parents up to 60 days after discharge.

Medical/Pharmacy Expenses:

The Sponsor(s) agrees to be financially responsible for all medical expenses by providing insurance information a credit card for medical providers to direct bill costs not covered by insurance. Sponsor(s) must complete the Medical Insurance and Credit Card Authorization form. Medical costs include: medical, dental, orthodontic, optical, urinalysis, lab work, psychiatric and psychological testing. If insurance and credit card information is not provided and payment is made by Spring Ridge Academy, a $50 administrative fee will be charged per occurrence.

1) Sponsor(s) understands and agrees to be financially responsible for the monthly tuition of $6,000.00. Sponsor(s) understands and agrees all monthly fees are payable in advance and due on the 1st day of each month.

2) Sponsor(s) understands and agrees that in the event the Student is taking prescription medication, the Student must have a medication review conducted by a psychiatrist. Sponsor(s) agrees to be financially responsible for the psychiatrist's review. Sponsor(s) agrees to be financially responsible for the cost of any medication purchased for the Student. All medication will be ordered through a local pharmacy. SRA agrees not to purchase, administer, or authorize any medication for the Student without prior consent of the Sponsor, unless in the case of an emergency and SRA is unable to contact the Sponsor(s).

3) Sponsor(s) agrees to be financially responsible for the cost of repairing or replacing any property lost, stolen, damaged, defaced, or destroyed by the Student.

4) Sponsor(s) agrees to be financially responsible for the costs in the event the student leaves SRA without authorization. An accounting of the expenses incurred by SRA while assisting the Sponsor(s) in finding and returning the Student will be made to the Sponsor(s).

5) Sponsor(s) agrees to be financially responsible for the costs of special dietary requirements. An accounting of the expenses incurred to purchase the foods will be made to the Sponsor(s). Special dietary requirements do not include vegetarian diets unless specific foods and/or products are required.

6) If Sponsor(s) is seeking a loan to cover the costs of the monthly tuition of $6,000.00, Sponsor(s) understands and agrees to be financially responsible for the accrued monthly tuition and future monthly tuition if the loan has not been obtained within thirty days of enrollment.

7) If Sponsor(s) is involved in a court action to cover the costs of the monthly tuition of $6,000.00, Sponsor(s) understands and agrees to be financially responsible for the monthly tuition until such time as the court action determines a different responsible party(s) and payment is received from the new or additional responsible party(s).

8) Sponsor(s) understands all monies due and payable must be received fourteen days prior to the Student's completion of the four phases.

9) Sponsor(s) agrees to pay the costs for collection of any amounts due under this agreement, including reasonable attorneys' fees, whether or not legal action is commenced, and in addition to pay interest (1½ percent per month) on all sums not paid within thirty (30) days after the due date.

10) Sponsor(s) understands, unless otherwise stated in writing, SRA takes no responsibility for the approval or processing of insurance reimbursements, payments, or billings.

11) Sponsor(s) understands terminating the Student's enrollment at Spring Ridge Academy prior to the completion of the four phases or before the minimum required 15 month period (as stated in the enrollment agreement) requires a written notice thirty days prior to the date of termination. If the Student leaves without a thirty day written notification, the parents will be billed for thirty days tuition. *All monies due and payable must be received fourteen days prior to the Student's departure.* If Spring Ridge Academy requests that Student leave, a tuition refund will be prorated from the date of departure. A $50 packing fee will be charged for all personal belongings to be shipped. The shipment will be sent C.O.D. via U.P.S.

12) Sponsor(s) hereby acknowledge that I/we have read the entire Financial Agreement and that I/we understand and agree to its provisions. This agreement may be modified or amended if the amendment is made in writing and is signed by both parties.

Date	Signature Mother/Guardian/Sponsor
Date	Signature Father/Guardian/Sponsor
Date	Signature SRA Representative

STATEMENT OF CLIENT RIGHTS (Rev. 11/01/2004)

All clients shall be afforded the following basic rights:

1. To be treated with dignity, respect, and consideration;
2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
3. To receive treatment that:
   a. Supports and respects the client's individuality, choices, strengths, and abilities;
   b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and
   c. Is provided in the least restrictive environment that meets the client's treatment needs;
4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;
5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;
6. To have grievances considered by a licensee in a fair, timely, and impartial manner;
7. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;
8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting, or exercising the client's rights;
10. To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);
11. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
    a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
    b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37;
    c. For video recordings used for security purposes that are maintained only on a temporary basis; or
    d. As provided in R9-20-602(A)(5);
12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);
13. To review the following at the agency or at the Department:
    a. This Chapter;
    b. The report of the most recent inspection of the premises conducted by the Department;
    c. A plan of correction in effect as required by the Department;
    d. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and
    e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;
14. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;
15. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;
16. To be offered or referred for the treatment specified in the client's treatment plan;
17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. § 36-512;
19. To be free from:
    a. Abuse;
    b. Neglect;
    c. Exploitation;
    d. Coercion;
    e. Manipulation;
    f. Retaliation for submitting a complaint to the Department or another entity;
    g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;

h. Treatment that involves the denial of:
   i. Food,
   ii. The opportunity to sleep, or
   iii. The opportunity to use the toilet; and
i. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;

20. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
21. To control the client's own finances except as provided by A.R.S. § 36-507(5);
22. To participate or refuse to participate in religious activities;
23. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene;
24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan;
25. To participate or refuse to participate in research or experimental treatment;
26. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;
27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;
28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility; and
29. If receiving treatment in a residential agency, an inpatient treatment program, a Level 4 transitional agency, or a domestic violence shelter:
    a. If assigned to share a bedroom, to be assigned according to R9-20-405(F) and, if applicable, R9-20-404(A)(4)(a);
    b. To associate with individuals of the client's choice, receive visitors, and make telephone calls during the hours established by the licensee and conspicuously posted in the facility, unless:
       i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
       ii. The client is informed of the reason why this right is being restricted; and
       iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
    c. To privacy in correspondence, communication, visitation, financial affairs, and personal hygiene, unless:
       i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
       ii. The client is informed of the reason why this right is being restricted; and
       iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
    d. To send and receive uncensored and unopened mail, unless restricted by court order or unless:
       i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
       ii. The client is informed of the reason why this right is being restricted; and
       iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
    e. To maintain, display, and use personal belongings, including clothing, unless restricted by court order or according to A.R.S. § 36-507(5) and as documented in the client record;
    f. To be provided storage space, capable of being locked, on the premises while the client receives treatment;
    g. To be provided meals to meet the client's nutritional needs, with consideration for client preferences;
    h. To be assisted in obtaining clean, seasonably appropriate clothing that is in good repair and selected and owned by the client;
    i. To be provided access to medical services, including family planning, to maintain the client's health, safety, or welfare;
    j. To have opportunities for social contact and daily social, recreational, or rehabilitative activities;
    k. To be informed of the requirements necessary for the client's discharge or transfer to a less restrictive physical environment; and
    l. To receive, at the time of discharge or transfer, recommendations for treatment after the client is discharged.

_____ _____

Mother/Guardian Signature Date

_____ _____

Father/Guardian Signature Date

SPRING RIDGE ACADEMY

Student Name_____ Date of Birth_____

PERMISSION TO PHOTOGRAPH

I/We the undersigned give permission and understand that Spring Ridge Academy staff will be taking an identification photograph for their files. _____ Yes _____ No

I/We agree to have our student photographed and to have the photograph placed in the Spring Ridge Academy history book and/or year book._____ Yes _____ No

I/We agree to have our student photographed and to have the photograph placed in a Spring Ridge Academy brochure and/or on the web page. _____ Yes _____ No

I/We agree to have our student photographed and to have the photograph placed in the Spring Ridge Academy password restricted Parent Page _____ Yes _____ No

MAIL RELEASE

As legal guardian of the above named student, I/we direct Spring Ridge Academy and its staff to send all outgoing and incoming mail (except for those sent or received from us) to the following address:

_____

I/We will take all responsibility for the mail. It is understood that Spring Ridge Academy is operating at my/our direction in this behalf.

LOST ITEMS RELEASE

Spring Ridge Academy recommends that expensive or sentimental items should not be brought to the program. Spring Ridge Academy makes every effort to protect and ensure the safekeeping of all the Student's personal belongings. I/We, the undersigned, understand and agree that Spring Ridge Academy shall not be responsible or liable for loss, damage, neglect, misplacement, or theft of the Student's property even if left behind on visits, leaves, or when the Student exits the Program.

_____ _____

Date Signature Mother/Guardian

_____ _____

Date Signature Father/Guardian

AUTHORIZATION FOR TREATMENT
CONSENT FOR COMMUNICABLE DISEASE TESTING, HIV AND STD TESTING

Student's Name_____ Date of Birth_____

AUTHORIZATION FOR TREATMENT

I/We, the custodial Parent(s) and/or legal Guardian(s) of the above named minor, hereby authorize Spring Ridge Academy, through health care professionals, to render the necessary health care to the above named minor.

I/We authorize and consent to any X-ray examination, anesthetic, inoculation, vaccination, medical or surgical diagnosis or treatment and hospital care to be rendered to the above named minor under the general or special supervision and upon the advice of a licensed physician. I/We hereby consent to X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a licensed dentist. I/We hereby authorize and consent for any psychological assessment, treatment, hospitalization and psychological testing from a licensed professional counselor, psychologist, and psychiatrist to be rendered to the above named minor.

I/We hereby give consent and authorize SRA to administer to the Student a routine urinalysis or blood test for drugs.

In my/our absence or in the event that I/we cannot be contacted, I/we hereby designate, empower, and authorize Spring Ridge Academy to act in my/our stead authorizing any specific procedures and/or assisting in making elective decisions relating to the above named minor's care. I/We are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees can be made as to the result of treatment or examinations taking place. It is the intent of this instrument to authorize, consent to and empower health care professionals selected by Spring Ridge Academy to give the care they deem necessary to my/our child, in my/our absence, or when I/we cannot be contacted, or in an emergency situation when immediate care is deemed to be in the best interest of the child by the health care professional's best judgment.

CONSENT FOR COMMUNICABLE DISEASE TESTING - HIV AND STD TESTING:

I/We further give consent for communicable disease testing, including but not limited to, HIV, Hepatitis and sexually transmitted diseases testing.

_____ _____
Date Signature Mother/Guardian

_____ _____
Expiration Date Signature Father/Guardian
(2 yrs from date of enrollment)

NOTARY:

State of_____)
)
County of _____)

The foregoing instrument was acknowledged before me this (date) _____ by (signers)

_____ *and*_____ .

_____ (Seal of Notary)
Signature of Notary

MEDICAL INSURANCE AGREEMENT

I/We, the parents/guardians of _____
(Student's Name)

agree to provide current medical insurance during the entire enrollment of above named Student at Spring Ridge Academy. I/We understand that I/we are responsible for all medical, dental, and psychological expenses for this student, notwithstanding any health insurance I/we may have. I/we also understand and agree that Spring Ridge Academy cannot guarantee that all healthcare providers will honor all insurance coverage. Consequently, I/we may have to file direct claims with my/our insurance carrier.

_____ _____
Signature of Mother/Guardian Date Signature of Father/Guardian Date

MEDICAL INSURANCE

Insured Name_____ Date of Birth_____

Address_____ SS# _____

City_____ State _____ Zip Code_____Home Phone_____

Insured's Employer_____ Work Phone_____

Insurance Company_____ Phone_____

Address_____ Group #_____

City_____ State _____ Zip Code_____

Dates of Coverage: From_____To_____

(Please attach a legible/enlarged copy of the front and back your insurance identification cards)

RELEASE OF MEDICAL INFORMATION

INSTRUCTIONS: This document will be utilized in the event a student requires a medical appointment in the vicinity of Spring Ridge Academy. The medical practitioner/health care provider line will be completed when needed.

To: _____ _____
Name of Medical Practitioner/Health Care Provider Date

Re: _____ _____
Name of Minor Child Date of Birth

I/We, Parent(s)/Guardian(s) of the above named minor child, hereby grant permission for you to furnish to Spring Ridge Academy Health Center a full report of the examination, diagnosis, prognosis, treatment, and recommendations regarding my/our above named minor child, together with copies of any other medical reports which you may have submitted to any other person, attorney, insurance carrier or administrative board.

This Release includes, but is not limited to, communicable disease testing, HIV and STD testing.

I/We understand that this Release will remain in effect during enrollment at Spring Ridge Academy and may be revoked by me/us at any time within that period when requested in writing.

I/We acknowledge that we have had a chance to ask questions which were answered to my/our satisfaction.

_____ _____
Date Signature Mother/Guardian

_____ _____
Expiration Date Signature Father/Guardian
(2 yrs from date of enrollment)

NOTARY:

State of_____)
)
County of _____)

The foregoing instrument was acknowledged before me this (date) _____ by (signers)

_____ *and*_____ .

_____ (Seal of Notary)
Signature of Notary

SPRING RIDGE ACADEMY
PRN PHYSICIAN ORDERS

I/We _____ Parent(s)/Guardian(s) of _____ have read the list of over the counter medications used at Spring Ridge Academy. _____ may use the following over-the-counter medications indicated by a check mark in the amounts and for the purposes indicated. All PRN medications will be administered according to SRA Policies & Procedures and in accordance with Arizona Department of Behavioral Health requirements.

_____ Diphenhydramine (Benadryl) tablets or liquid 25-50 mg po q 4h prn for allergic reaction

_____ Non-ASA cold tablets 1-2 tabs po q 6 h prn for cold or flu symptoms

_____ Tylenol 500 mg 1-2 tabs po q 6 h prn for pain or fever > 100 degrees F oral

_____ Ibuprofen 200 mg 1-2 tabs po q 6 h prn for pain or fever > 100 degrees F oral

_____ Cough drop 1 q 4 h prn for non-productive cough

_____ Guiatuss DM 5 cc po q 4 hr prn for productive cough

_____ Docusate Na (Colace) 1-2 gel caps po q hs prn for constipation. If no relief in 3 days, notify nurse.

_____ Milk of Magnesia 30 cc po q hs prn for constipation not relieved by docusate Na

_____ Sore throat lozenge 1 q 4 h prn for sore throat

_____ Saline nasal spray 2 sprays each nostril q 6 h prn for dry nasal membranes

_____ Antacid tablets 1-2 tabs po q 4 h prn for upset stomach

_____ Bismuth subsalicylate 30 cc po q 6 h prn for nausea not associated with flu symptoms

_____ Anti-itch medication topically q 4 h prn for insect bites and minor allergic reactions

_____ Anti-fungal medication topically q 4 h prn for minor fungal infections

_____ Triple antibiotic ointment topically q 4 h prn for minor abrasions

_____ Muscle pain relief medication topically q 4 h prn for muscle pain

Other: _____

The above orders will renew monthly until discontinued.

_____
Parent(s)/Guardian(s) Signature(s) Date

_____ _____
Physician Signature Date

CREDIT CARD AGREEMENT

I/We, the parents/guardians of _____ agree to provide credit card
(Student's Name)
information during the entire enrollment of above named Student at Spring Ridge Academy. I/We understand that I/we are responsible for all medical, dental, and psychological expenses notwithstanding any health insurance I/we may have. I/we authorize the health providers, including pharmacies, used by Spring Ridge Academy to charge my/our Visa/MasterCard (copy enclosed) for health services and prescriptions provided to the above named student. It is understood that Spring Ridge Academy cannot guarantee that all healthcare providers will honor all insurance coverage. Consequently you may have to file direct claims with your insurance company.

Credit Card Authorization:

I, _____, authorize the health providers of Spring Ridge Academy
(Name of Card Holder)

to charge my/our ____Visa ____MC - Acct. Number _____ Exp Date_____

Billing Address:_____

_____ _____
Signature of Cardholder Date

Please attach a legible/enlarged copy of your credit card.
Front and back of the cards are required.

REFERRAL INFORMATION

Student's Name *(Last, First, Middle)* **Date of Birth**

_____ _____

Who referred you to Spring Ridge Academy?

☐ Education Consultant _____

☐ Internet _____

☐ Friend _____

☐ Therapist _____

☐ Other– Please Provide Source

_____

I/We would like monthly status reports, copies of testing, and final reports sent to Educational Consultant or Placement Counselor _____ Yes _____ No

Please complete an Authorization to Use/Disclose Protected Health Information form if you have checked yes above. (See next page)

_____ _____

Date Signature Mother/Guardian or Patient

_____ _____

Date Signature Father/Guardian

SPRING RIDGE ACADEMY
13690 S. Burton Rd. – Spring Valley, AZ 86333
Office: (928) 632-4602 – Fax: (928) 632-7661

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

(*Reproduce this form as needed*)

Spring Ridge Academy (SRA) is authorized to use/disclose information as noted below about:

STUDENT NAME_____ Date of Birth_____

To/From the following person/organization:

NAME_____TITLE_____

ADDRESS_____

PHONE_____ FAX_____

_____ Admission and discharge summaries
_____ Psychological and/or Psychiatric evaluation(s), reports, testing, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations
_____ Treatment, aftercare plans and other similar plans
_____ Social, family, education, and vocational histories
_____ Verbal progress reports, observations and recommendations
_____ Information about how patient's condition(s) affects or has affected her ability to participate in school and to complete tasks or activities of daily living
_____ Academic & educational records, including achievement & other tests' results, reports of teachers' observations, and all other school or special education documents
_____ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: _____ Do not release these
_____ Other _____

Dates of care included: From _____ to _____ and
From _____ to _____

The information will be used/disclosed for the following purposes: _____

_____

_____

- I understand and agree that this Authorization will be valid and in effect until: _____
  I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
- I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Spring Ridge Academy.
- I understand that I may inspect and have a copy of the health information described in this authorization.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I understand that this professional will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.
- I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Signatures: _____ _____
Father/Guardian Signature Date Mother/Guardian Signature Date

I, an authorized representative from SRA, have discussed the issues above with the client and/or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature & Printed Name of Authorized SRA Representative Date

INFORMATION ACKNOWLEDGEMENT

I/We acknowledge I/we have received the following information (initial each item & sign below):

1)	Copy of the Client Rights (Parent Manual)	_____Initial
2)	An explanation of the fees that we are required to pay (Financial Agreement)	_____Initial
3)	Current telephone numbers for Arizona and Regional Behavioral Health Services and Child Protective Services (Parent Manual)	_____Initial
4)	Copy of the Spring Ridge Academy Formal Complaint Policy (Parent Manual)	_____Initial
5)	Written Description of Dress Code (Parent Manual)	_____Initial
6)	Informed that Spring Ridge Academy is not a secure facility (Enrollment Agreement)	_____Initial

_____ _____

Date Signature Mother/Guardian or Patient

_____ _____

Date Signature Father/Guardian

HIPPA ACKNOWLEDGEMENT

Per the new HIPAA (Health Insurance Portability and Accountability Act) it is our obligation to inform you of your right to read our Notice of Information Practices. Please sign below to acknowledge receipt of the Notice of Information Practices (attached and made a part of this enrollment packet).

I /we acknowledge that I/we have been provided a copy of the Spring Ridge Academy Notice of Information Practices as required by HIPAA (Health Insurance Portability and Accountability Act).

_____ _____

(Print Name) (Signature/Date)

_____ _____

(Print Name) (Signature/Date)

SPRING RIDGE ACADEMY - NOTICE OF INFORMATION PRACTICES

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

Spring Ridge Academy understands that medical and psychological information about you is personal. We are committed to protecting this information about you. This Notice of Information Practices applies to all of our records of your care generated and maintained by SRA.

Understanding Your Health Record Information

Each time you visit a hospital, physician, or other healthcare provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that you actually received the services billed for.
- A tool in medical education.
- A source of information for public health officials charged with improving the health of the regions they serve.
- A tool to assess the appropriateness and quality of care you received.
- A tool to improve the quality of healthcare and achieve better patient outcomes.

Understanding what is in your health records and how your health information is used helps you to:

- Ensure its accuracy and completeness
- Understand who, what, where, why, and how others may access your health information.
- Make informed decision about authorizing disclosure to others
- Better understand the health information rights detailed below.

Your Rights Under the Federal Privacy Standard

Although your health records are the physical property of the healthcare provider who completed it, you have certain rights with regard to the information contained therein. You have the right to:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. Health care operations consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under ‘ ‘ 164.502(a)(2)(i) (disclosures to you), 164.510(a) (for facility directories, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, like mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. Even in those cases in which you do have the right to request restriction, we do not have to agree to the restriction. If we do, however, we will adhere to it unless you request otherwise or we give you advance notice.
- You may also ask us to communicate with you by alternate means and, if the method of communication is reasonable, we must grant the alternate communication request.
- Receive and keep a copy of this notice of information practices. The law requires us to ask you to acknowledge receipt of your copy.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, if access would cause harm, we can deny or limit access. You do not have a right of access to the following:
  - Psychotherapy notes. Such notes are those that are recorded in any medium by a healthcare provider who is a mental health professional documenting or analyzing a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.
  - Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
  - Any of your health information that is subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. ‘ 263a, to the extent that the provision of access to the individual would be prohibited by law.
  - Information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

In other situations, the provider may deny you access but, if it does, the provider must provide you with a review of the decision denying access. These reviewable grounds for denial include:

- When a licensed healthcare professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of psychological and/or emotional, mental well-being of the individual or another person.
- When the PHI (Protected Health Information) makes reference to another person (other than a healthcare provider) and a licensed healthcare provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
- The request is made by the individual’s personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review.

If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.

- If you request amendment/correction of your health information. We do not have to grant the request if:
  - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If they amend or correct the record, we will put the corrected record in our records.
  - The records are not available to you as discussed immediately above.
  - The record is accurate and complete.

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain to our complaint official or to the Department of Health and Human Services. If we grant the request we will make the correction and distribute the correction to those who need it and those you identify to us that you want to receive the corrected information.

You may obtain an accounting of non-routine uses and disclosures those other than for treatment, payment, and health care operations, or of protected health information about them. We do not need to provide an accounting for the following:

- For disclosures to you.
- For disclosures authorized by you.
- For disclosures of limited data sets (partially de-identified data used for research, public health, or health care operations).
- For the facility directory or to persons involved in the your care or for other notification purposes as provided in ‘ 164.510 (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for the care of the individual, of the individual’s location, general condition, or death).
- For national security or intelligence purposes under ‘ 164.512(k)(2) (disclosures not requiring consent, authorization, or an opportunity to object).
- Correctional institutions or law enforcement officials under ‘ 164.512(k)(5) (disclosures not requiring consent, authorization, or an opportunity to object).
- That occurred before April 14, 2003.

If an accounting is requested, we will provide the following within 60 days:

- Date of each disclosure
- Name and address of the organization of person who received the protected health information.
- Brief description of the information disclosed.
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of the your written authorization, or a copy of the written request for disclosure.

The first accounting in any 12 month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

- Revoke you consent or authorization to use or disclose health information except to the extent that we have already taken action in reliance on the consent or authorization.

Our Responsibilities Under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you with this notice as our legal duties and privacy practices with respect to individually identifiable health information we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION WE MAINTAIN. SHOULD WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS YOU HAVE SUPPLIED US.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

SPRING RIDGE ACADEMY - NOTICE OF INFORMATION PRACTICES

How to Get More Information or to Report a Problem
If you have questions and/or would like additional information, you may contact the Executive Director at (928) 632-4602 x 105.

Complaints
If you believe your privacy rights have been violated, you may contact or file a complaint with the Executive Director, 13690 South Burton Road, Spring Valley, AZ 86333; (928) 632-4602 x105.

Examples of Disclosures for Treatment, Payment, and Health Operations

Treatment: If you give us consent by signing a release of information or with the regulatory consent granted by the Department of Health and Human Services, we may use or disclose your health information for treatment.

Example: A physician, nurse, or other member of your healthcare team will team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the healthcare team to do to treat you. Those other members will then document the actions they took and their observations. In that way, the primary caregiver will know how you are responding to treatment.

We will also provide your physician, other healthcare professionals, or a subsequent healthcare provider with copies of your records to assist them in treating you once we no longer are treating you.

Payment: If you give us consent or with the regulatory consent grated by the Department of Health and Human Services we may use or disclose you health information for payment.

Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

Health Operations: If you give us consent or with the regulatory consent granted by the Department of Health and Human Services we may use or disclose your health information for health operations (see definition above).

Uses and Disclosures Other than for Treatment, Payment, or Health Care Operations

Business Associates: We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associate so that they can perform the function(s) we have contracted with them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: We will communicate with parents or legal guardians only. All other communication will require a release consent unless pre-authorized by a parent or legal guardian.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post marketing surveillance information to enable to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information purpose as required by law or in response to a valid subpoena.

Health Oversight Agencies and Public Health Authorities: If a member of our work force or a business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.

The Federal Department of Health and Human Services (DHHS): Under the privacy standards, we must disclose your health information to DHHS as necessary for them to determine our compliance with those standards.