

RedCliff Ascent, Inc.

Enrollment Packet

*Please complete the following
forms and return them to:*

**RedCliff Ascent
757 South Main Street
Springville, UT 84663**

**Questions concerning these forms should be
directed to the Admissions Department**

**1-800-898-1244
1-801-491-2271
FAX: 801-491-2279**

STUDENT FAMILY INFORMATION

Name of person referring _____ Date _____

Relationship to student _____

Address _____

Home phone (____) _____ E-Mail _____

Student's Name _____ Age _____ DOB _____

Height _____ Weight _____ Gender _____

Place of birth _____ SSN _____

Birth Child? _____ Adopted? _____ If adopted, when? _____

Who has Legal custody of this Child? _____ Both/Mother/Father

Who has Physical custody of this Child? _____ Both/Mother/Father

Has this child had previous placements outside the home? _____

If yes, please list other homes, schools, and institutions with addresses, length of stay, reason for release.

Medical Insurance Company _____

Insurance Company Address _____

Telephone (____) _____ FAX _____ E-Mail _____

Policy, Group or Certificate Number _____

Name of Insured _____ Social Security # of Insured _____

Name of Insured's Employer _____

Employer's Address _____ Phone Number (____) _____

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY

1st _____ Phone Number (____) _____

2nd _____ Phone Number (____) _____

3rd _____ Phone Number (____) _____

MEDICAL REPORT FORM

A candid appraisal of your child’s health is necessary. Please complete every question on this form, so that we may know of any health conditions or medication requirements during your child’s participation in the program. All medications must be listed on the medical report form and sealed with students name in a pharmacy container. Medications that do not meet these requirements will be confiscated.

Participation in the RedCliff Ascent Outdoor Therapy program should not be considered if any of the following exist:

**Extreme obesity
Renal disease
Chronic tranquilizer use**

**Diabetes or Hypoglycemia
Arthritis
Pregnancy**

Patient’s Name: _____ Date of Birth: _____

MEDICATIONS AND ALLERGIES	YES	NO	PRESENT CONDITION OR MEDICATION AND DOSE
1. Is your child currently taking any prescribed medications?			
2. Has your child previously been on prescribed medications?			
3. Does your child have any specific allergies to foods, drugs or other substances?			

DOES YOUR CHILD HAVE OR HAS HE/SHE EXPERIENCED ANY OF THE FOLLOWING DURING THE PAST YEAR?	YES	NO	PRESENT CONDITION OR MEDICATION DOSE
4. Ear pain or any problem with hearing?			
5. Eye discomfort or other difficulties?			
6. Frequent or migraine headaches?			
7. Dizziness or fainting spells?			
8. Hay fever or nasal problems?			
9. Hives or skin allergies?			
10. Skin sores or rashes?			
11. Warts or sores on feet?			
12. A lump, mole or swelling?			
13. Chest pain or shortness of breath?			
14. Coughing?			
15. Sweating at night?			
16. Spitting or coughing up blood?			
17. Urinary burning, frequent urination or dark urine?			
18. Stomach aches, burning or indigestion?			
19. Difficulty starting urination or dribbling?			
20. Difficulty walking, running or lifting things?			
21. Pain in back, neck or joints?			
22. Excessive weight gain?			
23. Unexplained weight loss?			

MEDICAL REPORT FORM

HAS YOUR CHILD EXPERIENCED:	YES	NO	PRESENT CONDITION OR MEDICATION
24. A rupture or hernia?			
25. Diarrhea or unusual bowel movements?			
26. Any injury or illness not already noted?			
27. High blood pressure?			
28. Excess bleeding?			
29. Venereal disease?			
30. A tumor, growth, cyst or cancer?			
31. A knee or ankle injury?			
32. Arthritis or swollen and painful joints?			
33. Does your child currently wear glasses?			
34. A nervous breakdown?			
35. Appendicitis?			
36. Frequent colds?			
37. Rheumatism?			
38. Kidney disorders?			
39. Ear infection?			
40. Pneumonia?			
41. Scarlet fever?			
42. Long measles or three-day measles?			
43. Typhoid?			
44. Chicken pox?			
45. Polio?			
46. Chronic tranquilizer user?			
47. Hypoglycemia?			
48. Obesity?			
49. Renal Disease?			
50. Anemia?			
51. Mumps?			
52. Rheumatic fever?			
53. Birthmarks and/or tattoos?			
54. Seizures, convulsions or epilepsy?			
55. An ulcer?			
56. Asthma or wheezing?			
57. A back injury or deformity?			

HAS YOUR CHILD EVER HAD:	YES	NO	PRESENT CONDITION OR MEDICATION
58. Heart trouble or disease?			
59. Diabetes or sugar in the urine?			
60. Goiter or other thyroid problems?			

IMMUNIZATIONS:	DATE
Diphtheria/Pertussis (whooping cough)/Tetanus (DPT)	
Diphtheria/Tetanus (DT)	
Tetanus Toxoid	
Measles/Mumps/Rubella (MMR)	

FEMALES ONLY:	YES	NO	PRESENT CONDITION OR MEDICATION
61. Vaginal discharge?			
62. Pregnancy?			
63. Painful menstruation?			
64. Spotting between periods?			
65. Flowing longer than eight (8) days?			

Primary Care Physician _____ Phone (____) _____

Psychiatrist / Therapist _____ Phone (____) _____

Dentist _____ Phone (____) _____

Orthodontist _____ Phone (____) _____

Optometrist _____ Phone (____) _____

RedCliff Ascent
757 South Main Street, Springville, UT 84663 (801) 491-2271

CONSENT TO EXAMINATION & TREATMENT

Patients Name _____ Date of Birth _____
Last First Middle

I hereby 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 physician licensed under the provisions of the Medical Practice Act. I hereby consent to x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed under the provisions of The Dental Practice Act. Thereby, I authorize and consent to any treatment and psychological testing from a licensed psychologist or psychiatrist to be rendered to the above named minor. I understand that I am responsible for all medical, dental and psychological expenses notwithstanding any health insurance I may have. I have read the foregoing and understand the same.

Parent or Guardian Signature _____ Date _____

Please refer all medical billing and/or insurance to:

Name _____

Address _____

Home Phone (____) _____ Work Phone (____) _____

FAX Number (____) _____

MEDICAL INSURANCE

Insurance Company _____

Insurance Company's Address _____

Insurance Company Telephone Number(s) (____) _____

Policy Holder _____ Policy Holder SS # _____

Policy # _____ Group # _____ ID # _____

Employer _____ Employer's Address _____

RELEASE OF MEDICAL INFORMATION

I hereby authorize release of medical information regarding the above named patient to medical personnel at RedCliff Ascent, Inc.

Parent or Guardian Signature _____ Date _____

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POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT, that we _____ (hereinafter the "sponsor"), residing at _____, do hereby make, constitute, and appoint RedCliff Ascent Inc., a Utah corporation (hereinafter "RedCliff Ascent" which owns and operates programs known as RedCliff Ascent Inc., to be the true and lawful attorney, in fact for _____ (hereinafter the "Student"), who is my/our _____ for the purpose of providing custodial care and educational, therapeutic and clinical services in connection with the RedCliff Ascent Inc. (hereinafter the "Program").

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

1. To provide or obtain all medical, dental and psychiatric treatment and hospital care, and to authorize a physician to perform all procedures, that may appear to be medically necessary for the well-being of the Student.
2. To guide and discipline the Student as deemed necessary and reasonable by RedCliff Ascent (but not to include physical punishment).
3. To physically restrain the Student should he/she become a danger to himself/herself or to anyone else, as deemed necessary by RedCliff Ascent.
4. To allow the Student to participate in all activities that may risk physical injury or illness, as outlined in RedCliff Ascent's Enrollment agreement and Program description.
5. To search the person and personal effects of the student at any time and confiscate any items deemed by RedCliff Ascent to be contraband or counterproductive to the Student's successful completion of the Program.

This Power of Attorney shall be effective for a period of approximately _____ or for the duration of contracted care or upon termination of the Student.

IN WITNESS WHERE OF, I/we have executed this Power of Attorney this _____ day of _____, 20_____

Signature of Sponsor
(Father/Guardian)

Signature of Sponsor
(Mother/Guardian)

State of _____ County of _____

On this _____ day of _____, 20_____, personally appeared before me _____ and _____,

the signers of the foregoing Power of Attorney, who duly acknowledged to me that they executed the same.

Acceptance _____
RedCliff Ascent, Inc.

NOTARY PUBLIC
Residing at _____

By _____

Title _____

Date _____

Commission expires _____

MUST BE NOTARIZED!

ADOLESCENT INFORMATION & PSYCHOLOGICAL PROFILE

ATTENTION: It is very important that the following forms are completed in detail to assist in our efforts to provide a treatment plan that will best serve the student. The information filed on these forms will be held and maintained strictly confidential.

Identification

Student's Name _____ Age _____ Race _____

Social Security Number _____ DOB _____

Home Address _____ Phone (____) _____

Current Address _____ Phone (____) _____

Father's Name _____ Age _____ Race _____

Address _____ Phone (____) _____

Occupation _____ Work Phone (____) _____

Mother's Name _____ Age _____ Race _____

Address _____ Phone (____) _____

Occupation _____ Work Phone (____) _____

Stepfather's Name _____ Age _____ Race _____

Address _____ Phone (____) _____

Occupation _____ Work Phone (____) _____

Stepmother's Name _____ Age _____ Race _____

Address _____ Phone (____) _____

Occupation _____ Work Phone _____

Legal Guardian(s) _____ Age _____ Race _____

Address _____ Phone (____) _____

Occupation _____ Work Phone (____) _____

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PROFILE INFORMATION

Please describe the reason for your child's referral to our program, including behavioral, emotional and/or medical problems. Please use additional sheets of paper, if necessary.

At what age did the problems first occur? Describe in detail the transition of the problem from the first occurrence until now (including ages and dates of occurrences).

Is your child currently being treated for the problem(s)? If yes, what is the type of treatment/intervention, when did it start, with whom and where is this treatment taking place?

Please list past history of treatment and or interventions for this problem.

Were there any problems during pregnancy, labor or delivery with this child?

Were there any problems with development (i.e., walking, talking, toilet training)?

Describe any major illnesses and/or accidents.

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FAMILY PROFILE

Please list all family members

Name	Age	Relation	Living at home? Yes / No

Please describe the history of your child’s relationships with each family member. Include parents, stepparents, siblings and half or stepsiblings.

Please describe the family marriage history. Please include divorces, separations, re-marriages, etc., if any, and your child's age at the time and reaction to them.

Describe any hereditary or abnormal illnesses that have occurred or affected family and relatives, including emotional and/or learning problems.

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SOCIAL SKILLS & RELATIONSHIPS

How are your child’s relationships with each of the following?

	Excellent	Good	Fair	Poor
Family				
Others of same age				
Male				
Female				

Briefly explain any problems with relationships currently.

Has your child ever been arrested or charged with any crimes? If yes, describe what and when.

Has your child experienced traumatic events such as: sexual abuse, death, imprisonment, rape, physical abuse, violence, etc.? If yes, describe what and when.

List three issues you would like your child to address while in the RedCliff Outdoor Therapy Program.

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HISTORY OF SUBSTANCE USAGE/ABUSE

Check the substance(s) used/abused and the age first experienced.

Substance	Age first used	Frequency
Tobacco		
Beer		
Wine		
Hard Liquor		
Marijuana		
Hallucinogens (LSD, PCP, Angel Dust, etc.)		
Stimulants/uppers (cocaine, crack, methamphetamine, etc.)		
Depressants (sedatives, barbiturates, etc.)		
Opiates (heroin, methadone, etc.)		
Inhalants (glue, gasoline, paint, etc.)		

Please describe the mental or physical characteristics that seemed apparent from the use of any of the above substances.

Describe the student's attitude when confronted about substance abuse.

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ACADEMICS

What do you perceive as your child's current academic needs? _____

At what age and with what class did your child start school? (i.e., 1st grade, age 5) _____

Does your child struggle in school? _____ With what? _____

What grade did he/she start to struggle? _____

Has your child repeated any grades? _____ If yes, which grades? _____

Ever been suspended? _____ If yes, why? _____

Ever been expelled? _____ If yes, why? _____

Been in Special Ed or Resource Classes? _____ If yes, which? _____ Classification? (i.e., LD, BD) _____

What was the last grade your child completed? _____ What grade is your child currently in? _____

Name of School _____ Address _____

Name of Principal _____ Name of School Counselor _____

If not enrolled, last school attended _____

Please list the schools your child had attended.

SCHOOL ATTENDED	ADDRESS	GRADE	YEAR	REASON FOR LEAVING

Please list past employment.

EMPLOYERS NAME	DATES OF EMPLOYMENT

Has your child demonstrated violent behavior? _____ If yes, when and what were the circumstances? _____

Has your child ever tried to commit suicide? _____ If yes, when and what were the circumstances? _____

**THIS INFORMATION IS TO ASSIST REDCLIFF
IN THE EVENT OF A RUNAWAY / AWOL**

Student Name _____ SS# _____ Date of birth _____

Eye Color _____ Hair Color _____ Weight _____ Height _____ Age _____

Describe any birthmarks/tattoos/scars _____

Please give the name, phone, address of any individual or individuals the student may contact to assist in the case of a runaway attempt.

NAME	ADDRESS	PHONE

Describe any past attempts to runaway, methodology, procedures and mediums used (stolen car, bus, train, airplane, ride from a friend, etc.)

	No	Yes	Describe
Did student have substantial reason to run?	_____	_____	_____
Was student involved in illegal activities?	_____	_____	_____
Did student return home?	_____	_____	_____
Was student hostile or angry when approached?	_____	_____	_____
Did student lie or mislead police when approached?	_____	_____	_____
Did student run alone?	_____	_____	_____
Did student usually run with another student?	_____	_____	_____

Please provide any additional information that may assist in the case of a runaway/AWOL.

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ASSIGNMENT OF INSURANCE BENEFITS

Patient Name _____ Admission Date _____

Insurance Company _____

Policy Number _____

For the purpose of paying all or part of monies owing to RedCliff Ascent, Inc. for services it has or will render to the above patient, the undersigned hereby irrevocably assigns to RedCliff Ascent any benefit payments payable for the benefit of said patient by the above Insurance Company or Companies and all my rights and interest in said policy but only to the extent necessary to pay RedCliff Ascent services in full. Undersigned understands that the nature of patient's disability may be such that no benefit payments will be payable under the policy specified above. Any monies owing by the undersigned under the terms of this Agreement shall be paid in full within (30) days after billing by RedCliff Ascent unless other arrangements have been made. In the event that collection efforts are undertaken by RedCliff Ascent to enforce any of the terms of this Agreement, all expenses associated therewith, including reasonable attorney's fees, will be paid by the undersigned.

Date

Policyholder and/or patient

Date

Witness

<p>RedCliff Ascent 757 South Main Street, Springville, UT 84663 (801) 491-2271</p>
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CREDIT CARD POLICY

For your convenience RedCliff will accept Visa, Master Card, Discover and American Express credit cards. Credit cards can be used for the following purposes:

1. Tuition upon enrollment
2. Clothing and equipment fee
3. Medical bills (where insurance is not available)

POLICY FOR CREDIT CARD USE: In the event that your child is in need of one of the items mentioned above, a call will be made to you to authorize the purchase. RedCliff will then purchase the item with your authorization, we will bill your credit card. In the event that a credit card is not available for purchasing the items mentioned above, upon authorization from you, those purchases will be made by RedCliff and you will be billed for the items that your child needed.

Credit Card # _____ Expiration date _____

Credit Card Type _____

Signature of Cardholder _____

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CONTACT INFORMATION

Please list the appropriate name and phone number of the parent that will be contacting the therapist every other week. In addition, if an Education Consultant is involved, please list their name and number.

Name	Phone Number	Home/Work	Relationship

Please list non-custodial parents or other person(s) who might contact RedCliff asking for information about your child and what involvement they are to be allowed while your child is enrolled in the Program.

Name	Is contact allowed ?		What kind of information can be released to this person ?
	Yes	No	

Parent Signature

Date

RedCliff Ascent
757 South Main Street, Springville, UT 84663 (801) 491-2271

RedCliff Ascent

Notice of Privacy Practices

This notice describes how health information about you and /or your child may be used and disclosed and how you can get access to this information. Please review it carefully.

RedCliff Ascent is committed to protecting the privacy of personal information about you and/or your child. We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information, and how we may use and disclose your protected health information for treatment, payment, and other health-care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected personal health information and we also describe these in this notice. As a parent/guardian/sponsor of a student, or a student enrolled in RedCliff Ascent, you are entitled to receive notice about our privacy practices and how we may use and disclose personal health information, the choices and the rights which you have with regards to how this personal health information may be used and disclosed, and our obligations to protect the privacy of personal health information.

RedCliff Ascent is a therapeutic wilderness program that provides professional therapeutic services. This may include psychological and educational testing, treatment planning and therapy, and basic medical (first aid, etc) services.

Why do we gather and store personal health information?

We seek information from the parent/guardian/sponsor/student and former care providers about physical and mental health at the time of admission and throughout the course of treatment. This information is important in the planning and the provision of the treatment and to receive payment for our services. It is important for you to understand that these records contain personal health information that is protected by federal and state laws.

What do we do to protect personal health information?

RedCliff Ascent is required to maintain the privacy of personal health information and to provide you with a notice about our legal duties and privacy practices with respect to this information. We are also required to accommodate reasonable requests that you might make to provide you and future health providers with personal health information. Any disclosure of personal health information must follow the terms of this notice. We treat all personal information that we collect as confidential. We train our employees in our policies and procedures with regard to protection of confidential and personal health information. We restrict access to this information so that employees are only given that information that they need to know in order to provide services described in their job description. We only disclose to contracted health providers the information that is necessary for them to perform the contracted functions, and the contracted providers agreed to protect and maintain the confidentiality of personal health information to the same standards described in this notice.

How do we use and disclose protected personal health information?

We do not disclose personal health information unless we are allowed or required to by law, or unless we are given written authorization by someone with the legal right to do so. We may use and disclose personal health information in the following ways:

- 1) Treatment: We may use and disclose personal health information to plan, coordinate and provide health services to students while they are at RedCliff Ascent.
- 2) Payment: We may use and disclose personal health information to obtain payment for health-care services that we or other contracted entities have provided to the student.
- 3) Health-care operations: We may use or disclose personal health information for our health-care operations, including risk assessment and quality control functions.
- 4) Authorized Release of Information: The parent/guardian of a minor child, and a student who has reached the age of 18, can authorize the release of personal information. This authorization can be revoked at any time, but revocation will not impact the release of information that was disclosed prior to receipt of said revocation of authorization for release of records. Questions about written authorizations will be answered by the privacy officer at 435-878-2868.

- 5) Business associates: There are some services that are provided through contracts with business associates. In such situations, we may disclose personal health information to our business associates so they can perform the requested services. As noted, we require business associates to adhere to the same standards with regard to safeguarding personal information as described in this notice and in accordance with all applicable law.
- 6) Facility Directory: We may include the student's name and relevant demographic information in a facility directory made available to staff and therapists to assist them in making contact with parent/guardian and relevant referral source.
- 7) Family members: We may use or disclose your child's personal health information to notify a family member, personal representative or another person responsible for your child's care, provided you have the opportunity to agree or object to such disclosure. If circumstances do not permit us to obtain consent for the disclosure of personal health information, such as in a medical emergency, we may disclose personal health information to a family member or friend to the extent necessary to help with the immediate care or payment for the care. We will only do so if we determine that the disclosure is in your child's best interest. In all such cases, we will only disclose the health information that is directly relevant to that person's involvement with your child's health care.
- 8) Required by law: We may use or disclose personal health information to the extent that we are required by law to do so. Such uses or disclosures will be made in full compliance with the applicable law governing said uses and disclosures.
- 9) Public Health and Safety: We may disclose personal health information if we believe that disclosure is necessary to avert a serious and imminent threat to the health and safety of yourself, your child, or the health and safety of others. We may disclose personal health information for public health activities to a public health authorities authorized by law to collect or receive information for the purpose of controlling disease, injury or disability. Additionally, we may disclose personal health information to a person who may have been exposed to a communicable disease or otherwise be at risk of contacting or spreading a disease.
- 10) Food and Drug Administration: We may disclose personal health information to the FDA or persons under the jurisdiction of the FDA, as related to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- 11) Health Oversight Activities: We may disclose personal health information to a health oversight agency charged with overseeing the health-care industry. Disclosures will be made only as called for by law.
- 12) Judicial and Administrative Proceedings: We may disclose personal health information in the course of any judicial or administrative hearing in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request or other lawful process where we receive satisfactory assurance that appropriate precautions have been taken for privacy of said information. In all cases, we will take reasonable steps to protect the confidentiality of your and/or your child's health information.
- 13) Law Enforcement: We may disclose personal health information for a law enforcement purpose to law enforcement officials in compliance with and as limited by applicable law.
- 14) Fund Raising: We may contact you for any fund raising activities related to our organization. In all such cases we will obtain your written authorization prior to sending any information regarding you or your child.
- 15) Marketing: For market activities, we will obtain your written authorization prior to disclosing any personal health information regarding your child, unless we are not required by law to do so.
- 16) Research: We may use or disclose your child's personal health information for purposes of research by taking necessary precautions not to disclose personal identification information regarding you and/or your child or his/her personal health information – i.e., only the minimal necessary information shall be used and only that allowed by law.
- 17) Victims of Abuse, Neglect or Domestic Violence: We may disclose personal health information about an individual whom we reasonably believe to be a victim of abuse, neglect or domestic violence to a government authority, including a social service or protective service agency authorized by law to receive reports of child abuse, neglect or domestic violence. Any such disclosures will be made in accordance with and limited to the requirements of the law.
- 18) Limited Government Functions: We may disclose personal health information to certain government agencies charged with special government functions, as limited by applicable law. For example, we may disclose your child's health information to authorized federal officials for the conduct of national security activities, as required by law.

19) Organ Procurement: As allowed by law, we may disclose personal health information to organ procurement organizations for organ, eye or tissue donation purpose.

20) Coroner, Medical Examiners and Funeral Directors: We may disclose personal health information to a coroner or medical examiner to identify a “deceased person”, determine a “cause of death” or for other duties as authorized by law. We may also disclose personal health information to funeral directors in accordance with applicable laws.

21) Health and Safety: We may disclose personal health information to prevent or lessen a serious threat to a person’s or the public’s health and safety. In all cases, disclosures will only be made in accordance with applicable law and the standards of ethical conduct.

22) Worker Compensation: We may disclose personal health information in accordance with worker’s compensation laws.

What are my rights, and/or the rights of my child regarding the use and disclosure of personal health information?

You have the following rights regarding your and/or your child’s personal health information:

1) Right to Receive a Copy of this Notice: You may request a copy of this notice at any time, and one will be provided to you. A copy of this notice will be maintained in your child’s main health files at RedCliff Ascent. Also, a generic copy of this notice is posted in our business office.

2) Right to Receive Further Information: You have the right to contact our records/contact person at RedCliff Ascent (Box 1027, Enterprise, Utah 84725, 435-878-2868), if you want additional information about our privacy practices, your child’s privacy rights, or to disagree about a decision we made about your child’s personal information, or if you believe that your child’s privacy rights have been violated. The contact person will provide you with the information you need to file a complaint.

3) Right to Inspect And/or Receive a Copy of Your Protective Health Information: Upon written request, you have the right to access and/or obtain a copy of your / your minor child’s health information maintained by us. We may deny your request to inspect and copy in certain limited circumstances. Please contact our privacy officer at RedCliff Ascent for information you need to access and/or receive a copy of your minor child’s protected health information (reasonable copy costs will be charged).

4) Right to Amend Your Health Information: You have the right to request that we amend/change the records that we keep about you / your child if you believe that the information is incomplete or incorrect. You can make the request by sending a written request to our privacy officer. In certain circumstances, we may deny your request for amendment. All denials will be made in writing. If we deny your request, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.

5) Right to Request Additional Restrictions on Disclosure of Protected Health Information: You have the right to request that we place additional restrictions on how we use or disclose your / your child’s personal health information. We must obtain in writing, addressed to the privacy officer, any request or additional restrictions. Please note that we are not required to agree to your request.

6) Right to Request an Accounting of Disclosures: You have the right to request in writing an accounting of certain disclosures for personal health information that occurred after April 14, 2003, for most purposes other than treatment, payment, and operations. You are entitled to such an accounting for the six years prior to your request, though not for disclosures made prior to April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your personal information, a description of the personal information we disclosed, the reason for the disclosure, and other applicable information. If you request this list more than once in a twelve-month period, we may charge you a reasonable fee for creating and sending these additional reports.

7) Right to request confidentiality in certain communications. You have the right to request how we communicate with you in order to preserve your privacy areas for example, you may request that we call you only at a specified number, or by mail at a specific address or postal box. Your request must be made in writing to the privacy officer, and must specify how or where we are to contact you. We will accommodate all reasonable requests.

8. Right to File a Complaint: If you believe that your / your child’s privacy rights have been violated, you have the right to file a complaint with the privacy officer at RedCliff Ascent. Please file the complaint as soon as possible in writing, providing as much detail as you can about the suspected violation. You also have the right to file a written complaint with the Office of Civil Rights of

the United States Department of Health and Human Services. Upon request, the privacy officer will provide you with the information needed to file your complaint. Under no circumstances will we retaliate against you or your child for filing a complaint with us or with the Office of Civil Rights.

Uses or Disclosures Not Covered: Uses or disclosures of your / your child's personal health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

Changes to this Notice: We reserve the right to change our privacy practices and to alter this notice according to these practice changes. In the event that our notice changes while you / your child is enrolled in RedCliff Ascent, we will mail you a copy of our revised notice to the address you have supplied us.

RedCliff Ascent
757 South Main Street, Springville, UT 84663 (801) 491-2271

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION FORM CDCI

Patient's Name _____ Date of Birth _____

I hereby AUTHORIZE or REQUEST (please circle one) disclosure of confidential medical and mental health information in accordance with the terms and conditions set forth below.

Information requested from:

RedCliff Ascent
757 South Main St.
Springville, UT 84663

Name and Address(es) of person to whom information is to be released:

Purpose of disclosure: Continuation of care _____ Other (specify) _____

Extent or nature of the information to be disclosed: Please put YOUR INITIALS on the lines that apply.

____ Discharge Summary _____ Psychiatric Evaluation _____ History /Physical _____ Monthly Progress Letters
____ Psychological Evaluation _____ Education Reports _____ Treatment Plan
____ Other (specify) _____

Any information obtained will not be released by the above-named person or organization to any other persons or organizations unless I so authorize.

IN ACCORDANCE WITH FEDERAL REGULATION (42 CFR PART 2) This authorization shall remain in effect until _____.

I hereby also consent to the release of any and all alcohol and/or drug abuse treatment records under the same conditions outlined below. I understand that such information cannot be released without my consent, except under special circumstances.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the RedCliff Ascent office. However, your revocation will not be effective to the extent that RedCliff Ascent has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used to disclosed pursuant to the authorization may be subjected to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Date _____ Event _____ Condition _____

Signed this _____ day of _____, 20_____.

Parent signature

Date

Parent/Guardian signature

Date

Witnessed by

Date

RedCliff Ascent
757 South Main Street, Springville, UT 84663 (801) 491-2271

RedCliff Ascent, Inc.

Consent for RedCliff Ascent to release information from the records of _____ Date of Birth _____

RedCliff Ascent is released from all legal liability that may arise from the release of information authorized. I understand that the records may contain diagnosis, treatment and prognosis with respect to physical or mental conditions, to include records of alcohol and drug abuse, and/or treatment.

	Release RedCliff Ascent records to:	Type of information to be disclosed	Exp. date	Initial each
Referral Sources	PRIMARY CITY/STATE/ZIP	PHONE	Data Base* Treatment Reviews Discharge Summary Other	60 Days After Discharge
	SECONDARY CITY/STATE/ZIP	PHONE		
Mental Health Professionals	NAME CITY/STATE/ZIP	PHONE	Data Base* Treatment Reviews Discharge Summary Other	80 Days After Discharge
	_NAME	PHONE		
Court Officers	NAME CITY/STATE/ZIP	PHONE	Data Base* Treatment Reviews Discharge Summary Other	80 Days After Discharge
	NAME	PHONE		
Family Members or Others	NAME/RELATIONSHIP CITY/STATE/ZIP	PHONE	Progress Reports Other	80 Days After Discharge
	NAME/RELATIONSHIP	PHONE		
Physician	NAME CITY/STATE/ZIP	PHONE	Physician Orders Labs Data Base* Discharge Summary Other	One Year After Discharge
Schools, Teachers, Counselors	NAME CITY/STATE/ZIP	PHONE	Psychological Testing Academic Testing Academic Reports Other	Six Months After Discharge
	NAME CITY/STATE/ZIP	PHONE		
Insurance	Third party pay or agents		Data Base* Progress Reports Discharge Summary Other	Until Settlement Of Claim

*Data Base includes psychiatric, psychological and psychosocial evaluations, medical history and physical examination, and master treatment plan.

I understand that the records are protected and cannot be disclosed without my permission. Alcohol/drug treatment records are protected by federal regulation 42 CFR, part 2. I also understand that the above consents I have initialed can be withdrawn or changed by me at any time. I cannot take exception to actions that have taken place before I withdrew consent. The consents are limited to the respective ties listed above.

Parent/Guardian

Date

Parent Signature (where necessary)

Date

WRITTEN SUMMARY OF FEDERAL LAW AND REGULATIONS

Confidentiality of Alcohol and Drug Abuse Records

Federal Law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by this program. Generally, the program may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless:

- (1) The patient consents in writing; or
- (2) The disclosure is allowed by a court order; or
- (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violation of the Federal Law and regulations by a program is a crime. Suspected violating may be reported to appropriate authorities in accordance with Federal regulations.

Federal laws and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such crime.

Federal Laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate state or local authorities.

RedCliff Ascent
757 South Main Street, Springville, UT 84663 (801) 491-2271

INCOMING AND OUTGOING MAIL

RedCliff Ascent will provide envelopes specifically designated to send students mail in. All mail to the students **MUST** be in designated envelopes. **ANY MAIL ADDRESSED TO THE STUDENT THAT IS NOT IN THE DESIGNATED ENVELOPE WILL BE RETURNED TO THE SENDER.**

Parents/Guardians will have the responsibility to deliver the envelopes to those who have been given permission to write to the student. **IF A LETTER ARRIVES IN THE DESIGNATED ENVELOPE, WE WILL ASSUME IT IS AUTHORIZED BY THE PARENT/GUARDIAN FOR DELIVERY TO THE STUDENT.**

All outgoing mail will be sent directly to the custodial parent, regardless of the addressee.

Parent Information here:

Name: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

E-Mail Address: _____

Fax Number: _____

<p>RedCliff Ascent 757 South Main Street, Springville, UT 84663 (801) 491-2271</p>
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INSTRUCTIONS FOR COMPLETING FORM 100-A INTERSTATE COMPACT PLACEMENT REQUEST FORM

ABOUT THE COMPACT

Form 668 (100-A) is the sending agency's form written notice to the receiving state of its intention to make an interstate placement and a request for a finding as to whether the placement would or would not be contrary to the interests of the child. With most placements, it is also a formal request for a home study. Following review by the receiving state, it is the official notification that the proposed placement may or may not be made. A favorable finding means that the placement can be made in conformity with the Compact. An unfavorable finding means the placement would be unlawful. The actual making of the placement brings into operation a number of rights and obligations set forth in the Compact, primarily those contained in Article V, Retention of Jurisdiction.

Form 668 must accompany all requests for placement to which the Compact is applicable and it should be favorably acted upon by the receiving state before any Compact placement is made.

INSTRUCTIONS FOR COMPACT

In the first two blocks, enter the name and address of the ICPC Administrator (or Deputy) whose state is submitting the request (FROM) and the name and address of the ICPC Administrator (or Deputy) to whom the request is being forwarded to (TO).

Section I-Identifying Information:

Enter the full legal name, sex, ethnic group, and birth date of the child for whom this placement is proposed. If the child is known by a nickname, place it in parenthesis beside the legal name. If there is sufficient space to enter information for more than one sibling on one form, this may be done.

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

Enter the names of the legal mother and the legal father. In most instances, the legal mother and legal father will be birth parents. In cases where an adoption has been finalized, the adoptive parents will be the legal parents. If the parent(s) is deceased, enter "Deceased" after the parent(s) name. If parental rights have been voluntarily relinquished or terminated by the court, indicate in parenthesis beside the name, if you prefer in that instance to withhold the name, simply enter the status of the parent's rights.

Enter the complete name, address and telephone number of the agency or person who is responsible for planning for the child and who is financially responsible for the child. In most instances, these two items will be the same (the sending agency).

Section II-Placement Information:

Enter the complete name, address, and telephone number of the facility with whom the sending agency proposes to place the child.

The "Type of Care" is residential treatment.

Under "Legal Status" indicate whether the parent retains custody and guardianship or if the child is in the custody/guardianship of a sending agency.

Section III-Services Requested:

Under supervisory services check "Another Agency Agreed to Supervise." Check no boxes under "Initial Report" or "Supervisory Report."

Write in the name of the supervising agency (the residential provider unless otherwise arranged).

Check if you have included any information such as social history or court orders. They are not mandatory but should be included if you have them.

Sign as the sending person (agency representative if supervision is from an agency).

THE INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

What is it and how did it come about?

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

Some states enforce the compact law while others do not. Beginning in July 1996, Utah decided to comply with the basic intent of the Law in such a way that will be the least intrusive and inconvenient to you as a parent/guardian.

How will it work?

The Interstate Compact does **not** restrict you in any way from sending a child out of state to a treatment / emotional growth program. However, following the placement of your child, you simply need to forward form 100A to the Interstate Compact Coordinator in your state. (Please see attached listing for the contact person in your state).

The list below represents the Interstate Compact Contact persons for all the state in the Union. Please call your respective representative, obtain the address and forward the 100A form to that address.

<u>STATE</u>	<u>NAME</u>	<u>PHONE</u>	<u>STATE</u>	<u>NAME</u>	<u>PHONE</u>
AL	Anne Holiday	Not furnished	AK	Anne Pickering	907-465-2105
AZ	Ruby Pittman	602-235-9134 ext 7102	AR	Marty Nodurfth	501-682-8556
CA	Jackie Rodriguez	916-322-5391	CO	Chantal Smith	303-866-2998
CT	Sandra Matlock	860-550-6392	DC	Sharlyn Bobo	202-442-6100
DE	RoseMarie Holmquist	302-633-2698	FL	Samuel G. Ashdown	850-487-2760
GA	James Graves	404-657-3567	HI	Cynthia Goss	808-586-5699
	John Hutto	404-657-3564			
ID	Carolyn K. Ayres	208-334-5700	IL	Ron Davidson	217-557-5384
	Barbara Jarrett	208-334-5652			
IN	Nancy Ingle	317-232-4769	IA	Sarah Stark	515-281-5730
KS	Angie Casey	785-296-0918	KY	Mike Overstreet	502-564-5813
LA	Leola McClinton	225-342-4034	ME	Charles Gagnon	207-287-5060
MD	Stephanie Pettaway	410-767-7506	MA	Paula Sweeney	617-748-2375
MI	Dale Murray	517-373-6918	MN	Kelly Simmons	651-296-2725
MS	Patricia Hickman	601-359-4986	MO	MaryKay Kliethermes	573-751-2981
MT	Kandice Morse	406-444-5917	NE	Suzanne Schied	402-471-9245
NV	Connie Martin	775-684-4418	NH	Linda Bombaci	603-271-4708
NJ	Benita Rommel	609-292-3188	NM	Peg A. Tassett	505-827-8457
NY	James M. Keeler, Jr.	518-473-1591	NC	Osborne Shamberger	919-733-9465
ND	Deb Petry	701-328-3581	OH	Heidi Stone	614-466-9274
	Delores Friedt	701-328-4152			
OK	Margaret Linneman	405-522-1599	OR	Victor Congleton	503-945-6685
PA	Larry Yarberough	717-772-5505	RI	Everett Thornton	401-254-7077
SC	Mary Williams	803-898-7318	SD	Duane E. Jenner	605-773-3227
TN	Cheri Stewart	615-532-5618	TX	Carolyn Thompson	512-834-4474
UT	Mike Chapman	801-538-4364	VT	Margo Bryce	802-241-2141
Virgin Islands	Cheryl S. Hyndman	340-774-0930 1279	VA	RoseMarie Keith	804-692-1274
WA	Janette Benham	360-902-7987	WV	Nancy Chaloub	304-558-1260
	Tina Neswick	360-902-7984			
WI	Connie Klick	608-266-1489	WY	Maureen Clifton	307-777-3570
	Lynn Lehr	608-266-8501			
	Kathy Gerber	608-267-2075			

TO: (Name and Address of Compact Administrator in Receiving State)		FROM: (Name and Address of Compact Administrator in Sending State)	
SECTION I-IDENTIFYING DATA			
Notice is given of intent to place NAME OF CHILD:		SEX	DOB
NAME OF MOTHER		NAME OF FATHER	
NAME OF AGENCY OR PERSON RESPONSIBLE FOR PLANNING FOR CHILD			Telephone No.
ADDRESS			
NAME OF AGENCY OR PERSON FINANCIALLY RESPONSIBLE FOR CHILD			Telephone No.
ADDRESS			
SECTION II-PLACEMENT INFORMATION			
NAME OF PERSON(S) OR FACILITY CHILD IS TO PLACED WITH			Telephone No.
ADDRESS			
TYPE OF CARE <input type="checkbox"/> Foster Care <input type="checkbox"/> Group Home Care	<input type="checkbox"/> Residential Treatment Center <input type="checkbox"/> Child-caring Institution <input type="checkbox"/> Institutional Care <input type="checkbox"/> Article (VI)	<input type="checkbox"/> Parent <input type="checkbox"/> Relative (Not Parent) Relationship: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Adoption Subsidy/IV-E Assistance To be completed in: <input type="checkbox"/> Sending State <input type="checkbox"/> Receiving State
LEGAL STATUS <input type="checkbox"/> Sending Agency Custody/Guardianship <input type="checkbox"/> Parent Relative Custody/Guardianship <input type="checkbox"/> Court Jurisdiction Only		<input type="checkbox"/> Parental Rights Terminated-Right to Place for Adoption <input type="checkbox"/> Unaccompanied Refugee Minor <input type="checkbox"/> Other:	
SECTION III-SERVICES REQUESTED			
Initial Report (if Applicable) <input type="checkbox"/> Parent Home Study <input type="checkbox"/> Relative Home Study <input type="checkbox"/> Adoptive Home Study <input type="checkbox"/> Foster Home Study	Supervisory Services: <input type="checkbox"/> Request Receiving State to Arrange Supervision <input type="checkbox"/> Another Agency Agreed to Supervise <input type="checkbox"/> Sending Agency to Supervise	Supervisory Reports: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Upon Request <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"/> Home Study of Placement Resource <input type="checkbox"/> Other Enclosures			
SIGNATURE OF SENDING AGENCY PERSON			DATE SIGNED
SIGNATURE OF SENDING STATE COMPACT ADMINISTRATOR OR ALTERNATE			DATE SIGNED
SECTION IV-ACTION B			
<input type="checkbox"/> Placement May be Made <input type="checkbox"/> Placement Shall Not be Made	REMARKS		
SIGNATURE OF RECEIVING STATE COMPACT ADMINISTRATOR OR ALTERNATE			DATE SIGNED