



REDCLIFF ASCENT, INC.
ENROLLMENT AGREEMENT/FINANCIAL CONTRACT

This Agreement is entered into the _____ day of _____ 20____, by and between RedCliff Ascent, Inc., a Utah corporation (hereinafter “Program” or “RedCliff”) and _____ (hereinafter “Sponsor(s)”).

In consideration of the mutual promises set forth in this agreement, Program, and Sponsor(s), (hereinafter “Parties”), agree as follows:

1. SPONSOR(S)

Sponsor(s) affirm they are the legal Parent(s)/Guardian(s) with full legal/joint physical custody of _____ whose date of birth is _____, 19____, (hereinafter “Participant”) whose Social Security Number is _____.

Sponsor(s) expressly desire to contract for Participant’s enrollment in Program according to the terms of the Agreement. Sponsor(s) hereby acknowledges an understanding of the Agreement and the implications of entering therein and are proceeding with full knowledge of the terms and conditions having reviewed and read the contents thereof. Parties to this contract agree that Program shall be entitled to rely on the representations of Sponsor(s) with respect to all information given about Participant. Sponsor(s) agree(s) to be forthright and truthful about all considerations that must be disclosed to representatives of Program to insure the safety of Participant and others who may be assigned to the same group. Such considerations include both medical and psychological factors that may affect the performance of the contract by Program.

2. ENROLLMENT OF PARTICIPANT

Upon the completion of this Agreement, Program shall accept Participant for enrollment and promises to undertake and provide a wilderness experiential expedition. Program commits to doing its best in a highly developed planned experience for the betterment of Participant.

3. CONTRACT PERIOD

This Agreement is for a minimum period of 30 days of wilderness program which begins upon the arrival of Participant at the location site of Program..

4. SPONSOR(S) CONSENT FOR PARTICIPANT TO TAKE PART IN ENTIRE WILDERNESS PROGRAM AND AUTHORITY TO TRANSPORT PARTICIPANT

Sponsor(s) give(s) informed consent for Participant to take part in all of the activities of Program and hereby acknowledges that he/she/they are fully aware that parts of Program are demanding, rigorous, dangerous and stressful. Sponsor(s) further give(s) his/her/their authority to Program personnel to physically transport Participant from the RedCliff office to the field, and back when necessary, by any means which Program personnel deem reasonable and appropriate, including, but not limited to, hiking, pack animals, vehicles belonging to Program employees, passenger cars, trucks, motorcycles, 4-wheel-off-road and recreation vehicles, leased aircraft or by any commercial carrier such as trains, buses or aircraft. Sponsor(s) give(s) his/her/their express authority to Program personnel to utilize reasonable physical force upon Participant in order to protect Participant, Program personnel, or others from physical injury or threat of injury from Participant.

5. ESCORTING YOUTH FROM HOME TO PROGRAM

Sponsor(s) agree(s) to arrange for escort services to Program in Enterprise, Utah. Sponsor(s) further agree(s) that said arrangements are separate and apart from this agreement with Program. Program will provide reference(s) to Escort Agencies upon request. Sponsor(s) agree(s) that said reference does not constitute endorsement for legal purposes. Sponsor(s) acknowledge(s) and agree(s) that Escort Agencies are independent contractors and not agents or employees of Program and that Program has no liability, obligation or legal responsibility for the acts or omissions of Escort Agencies.

6. FINANCIAL PROVISIONS

A. NON REFUNDABLE ENROLLMENT FEE AND TUITION

Sponsor(s) agree(s) that the enrollment fee and tuition described below shall be paid either prior to, or, at the time of enrollment. Failure to make the enrollment fee and tuition payment may result in the denial of enrollment of Participant. The first 30 days tuition and enrollment fee are non-refundable.

Tuition: Sponsor(s) understand(s) the cost of the program is \$440.00 per day. Sponsor(s) agree(s) to pay \$13,200.00 tuition for the first 30

days of enrollment. Sponsor(s) understand(s) and agree(s) that the preparation and cost for Participant begins immediately upon acceptance of Participant by Program.

Clothing And Enrollment Fee: Sponsor(s) shall pay to Program \$1,400.00 for the initial intake fee which includes: clothing, equipment, and other intake services deemed appropriate by Program.

A summary of Sponsor(s) obligation for the first 30 days tuition and enrollment fee, is as follows:

First 30 days Tuition:	<u>\$ 13,200.00</u>
Clothing & Enrollment Fee:	<u>\$ 1,400.00</u>
Total Tuition & Enrollment Fee due upon enrollment for the First 30 days:	<u>\$ 14,200.00</u>

B. TUITION FOR EXTENSION OF ADDITIONAL DAYS IN PROGRAM

After approximately 20 days in Program, Participant's therapist will contact Sponsor(s) regarding the necessity of additional time in Program. If it is deemed necessary by the therapist, and if Sponsor(s) agree(s) to extend Participant's time in Program, Parties agree the following will occur:

1. The therapist will instruct Sponsor(s) to contact the business office to immediately make financial arrangements for payment;
2. The therapist will notify the business office of Sponsor(s) verbal approval of the extension and therapist will instruct the business office to immediately mail an invoice to Sponsor(s);
3. Sponsor(s) will make payment prior to the day the extension of Program begins. Failure to make the extension payment will result in the expulsion of Participant from Program.

C. CREDIT CARD POLICY

For your convenience, Program will accept Visa, Master Card, Discover and American Express credit cards. Credit cards may be used for tuition, enrollment fee and miscellaneous items, i.e. medical bills where insurance is not available, prescriptions, etc. If Participant is in need of miscellaneous items, Program will purchase item(s) with Sponsor(s) authorization and will bill Sponsor(s) credit card.

Credit Card No: _____

Card Security Code: _____

Credit Card Type: _____ Expiration Date: _____

Name on Card: _____

Billing Address: _____

Authorization Signature of Cardholder: _____

D. INSURANCE

It is understood between the Parties from the beginning of this agreement that the actual cost per day of this Program is a minimum of \$440.00 per day whether paid by insurance or directly by Sponsor(s). Sponsor(s) understand(s) that they are ultimately responsible for the payment of all monies owing to RedCliff Ascent Inc., whether or not there is insurance available and whether or not the insurance company makes payment. Sponsor(s) agree(s) to cooperate fully with RedCliff Ascent Inc. to secure insurance payment if such payment is available to Sponsor(s). If RedCliff Ascent Inc., is able to obtain pre-certification of insurance coverage, RedCliff Ascent Inc. will accept from the insurance company up to \$440.00 per day which represents the actual cost of Program. If the insurance payment is less than \$440.00 per day, Sponsor(s) agree(s) to immediately pay the difference between the total costs of Program, \$440.00 per day, and the amount paid by the insurance company plus initial enrollment fee.

RedCliff Ascent Inc. agrees to bill Sponsor(s)' insurance based on pre-certified verification of coverage for treatments described within Program. Sponsor(s) agree(s) to provide all necessary insurance information to RedCliff Ascent Inc., including all forms necessary to cause a proper timely payment arrangement to exist between Sponsor(s)' insurance carrier and RedCliff Ascent Inc. Both parties understand and agree that time is of the essence, and that delays in insurance payment must not be caused by Sponsor(s)' negligence or bad faith delays by either Sponsor(s) or Sponsor(s)' insurance company

E. ADDITIONAL COSTS AND EXPENSES:

Sponsor(s) agree(s) to pay the following expenses of Participant: (1) Transportation from home to the location designated by Program; (2) all necessary medical and hospital expenses incurred for the health and safety of Participant, with the exception of the initial physical examination which will be provided by Program; and (3) Participant's personal needs, including clothing and other personal items i.e. medication, eye wear, dental care, braces, shoes, etc., Sponsor(s) understand(s) the additional expenses will be billed to Sponsor(s) and Sponsor(s) agree(s) to pay these additional charges within ten days of the date of the invoice.

F. LATE PAYMENTS AND INTEREST:

In the event an extension of Program is deemed necessary, Sponsor(s) agree(s) to pay for said extension prior to the day the extension begins. Sponsor(s) further agree(s) to pay a late fee of five percent (5%) on any amounts not paid within 10 days of date of invoice. In

addition, any amounts not paid when due shall bear interest at twenty-four percent (24%) per annum until paid, both before and after judgment.

Sponsor(s) understand(s) a financial hold may be placed on any past due account. A financial hold will temporarily suspend academic reporting and clinical phone calls/family therapy. Sponsor(s) will be referred to the financial office until default in payment is cured. Failure to reconcile all financial obligations will result in Participant's discharge from Program. Sponsor(s) understand(s) Program may gather financial information from major credit reporting agencies.

G. RESPONSIBILITY FOR DAMAGE TO PROPERTY BY PARTICIPANT:

Sponsor(s) agree(s) to be financially responsible for the cost of repairing or replacing any property damaged, defaced, or destroyed by Participant while enrolled or participating in Program.

H. EXPENSE FOR THE ASSISTANCE IN THE RETURN OF RUNAWAY PARTICIPANT:

In the event Participant becomes a runaway from Program, Program will use reasonable efforts to assist Sponsor(s) in finding Participant and in obtaining the safe return of Participant to Program. An account of the expenses incurred by Program while assisting Sponsor(s) in finding and returning Participant to Program will be maintained. Sponsor(s) shall be responsible for all such expenses. Sponsor(s) shall also be responsible for the full amount of expenses incurred if Participant runs away prior to arrival at Program.

I. RESPONSIBILITY FOR LOSS OR DAMAGE OF PARTICIPANT'S PROPERTY

Program agrees to use due diligence to protect the property of each Participant within the reasonable expectation of its role. However, where damage or loss occurs to the property of Participant, either due to the negligence or actions of Participant, or by accident, then Sponsor(s) agree(s) to hold harmless Program and its staff from all liability for such loss or damage.

J. COST OF COLLECTION AND ATTORNEYS FEES DISCLOSURE

Sponsor(s) agree(s) that in the event that sums remain outstanding and a collection process is necessary Sponsor(s) will pay for all cost of collections including reasonable attorney's fees and court costs.

7. RESPONSIBILITY FOR MEDICAL INSURANCE

Sponsor(s) agree(s) to provide proof of medical/health insurance for Participant entering Program. If not currently covered by any medical/health insurance plan, Sponsor(s) agree(s) to purchase insurance to cover Participant while enrolled in Program. Participant is currently covered by:

Insurance Company: _____

Policy Number: _____ Insurance Co Phone Number: _____

8. RESPONSIBILITY FOR ILLNESS, INJURIES OR ACCIDENTS

Sponsor(s) shall waive any claim for any injuries, illnesses, or other damages occurring to Participant during the term of enrollment, including any resulting from Participant taking part in Program and the activities of Program. Sponsor(s) agree(s) to indemnify, defend, and hold Program harmless for any such injuries, illness or other damages to Participant.

9. AUTHORIZATION FOR MEDICAL CARE OF PARTICIPANT

In the event of any accident, injury, illness, or other necessity, Program is hereby authorized by Sponsor(s) to provide medical and hospital care and to authorize a physician to perform any procedures or tests that may be medically necessary for the well-being of Participant, and authorize the release of medical information about Participant to Program.

10. AUTHORIZATION FOR SEARCH

Sponsor(s) hereby give(s) consent and authorize(s) Program to search the personal effects and the person of Participant for his/her own safety and the safety of others in Program including other participants and the representatives of Program. It is agreed by Sponsor(s) that Program is authorized to confiscate any and all items deemed by Program as dangerous, harmful or otherwise deemed to be contraband. The disposition of all dangerous, harmful or contraband items shall be the sole responsibility of Sponsor(s).

11. AUTHORIZATION FOR MEDICAL EXAMINATION

Sponsor(s) hereby give(s) consent and authorize(s) Program to administer a routine physical examination to Participant. Such an examination will be conducted with the least intrusion necessary but sufficient to determine fitness for Program including current medical conditions not represented or not known at the time of Participant's introduction and qualification to enter Program. Sponsor(s) also give(s) consent and authorize(s) screening for any communicable diseases.

12. AUTHORIZATION FOR RESTRAINT

Sponsor(s) hereby give(s) his/her/their express authority and consent to authorized Program Personnel, where appropriate to the circumstances, to utilize reasonable physical force to physically restrain, control and detain Participant for and including, but not limited to the following purposes: Transportation to and from the Program; to prevent Participant from running away from Program; to protect Participant, or others from physical injury or threat of injury or damage to property by Participant.

13. CONTINUUM OF CARE AGREEMENT

Sponsor(s) agree(s) to attend either support groups or family therapy while Participant is in Program. References to support groups or family

therapists in Sponsor(s) area may be obtained from Program.

14. AGREEMENT TO ATTEND GRADUATION

Sponsor(s) agree(s) to attend Program's two-day graduation. Program will provide the dates and details of the graduation ceremony. Graduation is an earned event. Should Sponsor(s) withdraw Participant before treatment objectives have been met, as determined by the treatment team, Participant may not take part in the graduation ceremonies. Exemptions may be obtained to this policy in extenuating circumstances.

15. CHOICE OF JURISDICTION OF LAW AND OTHER MATTERS

Sponsor(s) agree(s) to be subject to the jurisdiction of the Utah Courts in any dispute between the Parties of this Agreement. Moreover, the Parties agree that the Utah Law shall govern this Agreement. Failure of either Party to enforce any term or provision of this agreement shall not constitute or be construed as a waiver of such term or provision of the right to enforce it. If any provision of the Agreement is construed to be overbroad as written, and by some legal theory unenforceable, Parties agree that the remaining provisions shall, nevertheless, remain enforceable according to applicable law.

16. EARLY ENROLLMENT TERMINATION

A. TERMINATION BY PROGRAM

Program reserves the right to terminate this Agreement at any time due to illegal, uncontrollable, or dangerous actions by Participant, unreported or previously unknown medical conditions, prior injuries, or for any other reason whatsoever as deemed reasonably necessary by Program, in its sole discretion. It is agreed between Parties that in the event of such termination by Program, Sponsor(s) shall not be entitled to a refund of any fee. At the sole discretion of Program, as a reasonable resolution to the actions of Participant, Participant may be invited to participate in Program at a later date if the conditions that caused Participant's termination from Program no longer exist.

B. WITHDRAWAL BY SPONSOR(S)

In the event Sponsor(s) withdraw(s) Participant from Program prior to the expiration of the 30-day term, all provisions outlined in Section 2 are agreed to be declared by the Parties as null and void. Furthermore, it is agreed that Sponsor(s) shall not be entitled to a refund of any fee. "Non-refund of tuition" is not considered by either Party to this Agreement as a penalty for early withdrawal of Participant. Instead, Parties agree that because of the "cost amounts" of such items as staff salaries, incurred debt reduction, staff schedules, inventories, operating expenses, etc., are difficult, if not impossible to estimate, and the inability or difficulty of finding alternative Participants partway through a term, the policy of non-refundable tuition appears to each of the Parties as a reasonable estimate of Program's losses associated with early withdrawal of Participant.

C. WITHDRAWAL AS A RESULT OF CUSTODY DISPUTE:

Program shall not be responsible or obligated to resolve, referee, or determine the custodial rights of the parents or guardians of a Participant. Sponsor(s) acknowledge that in the event a parent of Participant, regardless of their custodial rights over Participant, demands the termination of Participant's enrollment in Program, Program shall allow the termination and withdrawal of Participant's enrollment in Program by such parent. Such termination or withdrawal shall require twenty-four (24) hours prior written notice of the withdrawal or termination. In the event a custodial dispute involving Participant interferes with or disrupts the participation of Participant in Program, including without limitation the early removal or withdrawal of Participant from Program by Sponsor(s), or a parent of Participant as part of a custodial dispute, Sponsor(s) shall not be entitled to a refund of any fee and shall be responsible for a Custodial Dispute Termination Fee of \$ 750.00. Sponsor(s) hereby agree(s) to indemnify and hold Program harmless from any and all liability, obligation, costs, or attorneys fees associated with any custody dispute or dispute over the right of Sponsor(s) to enroll Participant in Program

17. SCOPE AND MEANING OF AGREEMENT:

Sponsor(s) hereby acknowledge(s) that he/she/they has/have/read the Agreement and that he/she/they understand(s) and assent(s) to it's provisions. This agreement constitutes the entire Agreement between the Parties, except as noted herein:

18. JOINT AND SEVERAL LIABILITY

If more than one person or entity shall execute this Agreement as Sponsor or if there shall be a guarantor of this Agreement, then the obligations of Sponsors and/or guarantor hereunder and of any persons or entities shall be joint and several.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the last date set forth below

SPONSOR(S)

RedCliff Ascent, Inc. a Utah Corporation

Sponsor Signature

By

Dated this _____ day of _____, 20____.

Title

Sponsor Printed Name

Sponsor Street Address

Sponsor City, State, Zip

Sponsor Social Security Number

Sponsor Signature

Dated this _____ day of _____, 20____.

Sponsor Printed Name

Sponsor Street Address

Sponsor City, State, Zip

Sponsor Social Security Number

REDCLIFF ASCENT

ENROLLMENT PACKET

***PLEASE COMPLETE THE FOLLOWING FORMS
AND RETURN THEM TO:***

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

***QUESTIONS CONCERNING THESE FORMS
SHOULD BE DIRECTED TO THE ADMISSIONS DEPARTMENT
1-800-898-1244
FAX: 801-491-2279***

Revised 11/2008

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, 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 (____) _____

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 _____

REDCLIFF ASCENT
757 South Main Street, Springville, Utah 84663, 801-491-2271

ASSIGNMENT OF INSURANCE BENEFITS

If applicable, please sign and return

Patient Name _____ Admission Date _____

Insurance Company _____

Policy Number _____

For the purpose of paying all or part of monies owing to Redcliff Ascent 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 attorneys fees, will be paid by the undersigned.

Date

Policyholder and/or patient

REDCLIFF ASCENT

757 South Main Street, Springville, Utah 84663 801-491-2271

**CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION
FORM CDCI**

Patient's Name _____ Date of Birth _____

I hereby AUTHORIZE and/ or REQUEST disclosure of confidential medical and mental health information in accordance with the terms and conditions set forth below.

Information requested from:

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

Redcliff Ascent
PO Box 1027
Enterprise, UT 84725

Information requested from:

Redcliff Ascent
PO Box 1027
Enterprise, UT 84725

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

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 or 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.

Parent signature

Date

Parent/Guardian signature

Date

REDCLIFF ASCENT
757 S. Main Springville, UT 84663
Phone 1-800 898-1244 FAX 1-801 491-2279

Client Rights/Parent Liason Rights

As representatives of RedCliff Ascent, Inc. all employees will conduct himself/herself in a professional and polite manner at all times. RedCliff Ascent will deliver information to Sponsors that, to their knowledge, is accurate and helpful.

Conversely, RedCliff Ascent employees have the right to be treated with respect and dignity while distributing information to parents, referral sources and other sponsors. If at any time the employee thinks that he/she is being treated in an abusive fashion, he/she will follow this protocol:

- 1) If it is felt that the caller is escalating in tone, language and content, the employee can ask for a brief pause in the conversation for the caller to regain composure before continuing the conversation.
- 2) If the caller's tone, language and content continue to escalate, and the employee thinks that it is reaching an abusive level, they can state the call will be terminated. The caller is invited to call back when the call can reach a more productive end. The employee then terminates the call.
- 3) If the employee is subject to abusive behavior for a second time from the same caller the caller will be informed that all further communication will take place in written updates. These updates can be e-mailed or faxed to the caller.

If you have any questions or concerns regarding this policy, please contact RedCliff Ascent field office during regular business hours (MST) at (435) 878-2868. Thank you for your cooperation.

Dear Parent or Guardian,

RedCliff Ascent has partnered with 4Care Pharmacy to better serve the medication and prescription needs of your student. 4Care Pharmacy dynamically interacts with our database to more effectively provide this critical service on a timely basis. Because of the nature of drug therapy and the restrictions imposed by insurance companies, the information requested below is vital in making sure your student receives the needed medications

In order to take advantage of this service, you will need to review the “Purchase terms and Conditions” and **submit the “Perscription Purchase Agreement and Payment Authorization Form.”** Please select payment type, either credit card or personal check.

In addition, to participate in this automated system it is necessary for us to have your insurance data on file with us. In most cases, that information has already been provided by you at the time of enrollment. We will contact you if that information needs to be updated.

As always, please feel free to contact us with any questions you may have, or you may contact 4Care Pharmacy directly at 801-380-8061.

Sincerely,

Karen Hiatt
Medical Coordinator
RedCliff Ascent



Prescription Purchase Agreement and Payment Authorization Form

Fax or mail this form to the above address

*** Required information**

Patient/Resident Name *: _____

Patient/Resident Birth Date *: _____

Financially Responsible Party/Cardholder Name *: _____

Financially Responsible Party/Cardholder Address *: _____

Cardholder E-Mail: _____

Cardholder Contact Phone *: _____

Pay by: (Check One) Credit Card ____ Debit Card ____ Personal Check ____

Credit/Debit Card # * if paying by card: _____

Credit/Debit Expiration Date * if paying by card: _____

By my signature below I certify that I have read and agree to the Prescription Purchase Terms and Conditions and all enclosed materials. I agree and authorize, on an ongoing basis, _____ (the Care Provider) and/or 4Care Pharmacy to debit my credit/debit card identified above for medicine and/or medical supplies, including shipping and service charges, where applicable, for each prescription provided to the Patient/Resident identified above as properly prescribed or ordered by his/her physician. **Payment of prescription copay(s) must be received by 4Care Pharmacy within 30 days of billing statement to ensure no interruption in the patient/resident's medication regimen.** I understand that my credit/debit card information will be kept securely on file by the Care Provider and that my card will be charged upon delivery of each prescription or order for amounts not covered by prescription insurance. I agree to be bound by the applicable Card Issuer Agreement in each instance. I will notify the Care Provider in writing upon revocation of my authorization or upon any change in address, e-mail, or credit/debit card expiration date. I understand that I will receive a receipt on a regular basis by mail or e-mail for each and every charge. I have read and agree to be bound to the terms of the refund policy of the Care Provider and/or 4Care Pharmacy.

Financially Responsible Party/Cardholder Signature: _____ Date Signed: _____

Prescription Insurance Data

*** Required for insurance processing**

Prescription Insurance Policyholder *: _____

Policyholder Address *: _____

Policyholder Social Security # *: _____

Employer *: _____

Prescription Insurance Company *: _____

See back of card for: Insurance Address *: _____

Phone *: _____

BIN Number *: _____

Policy/Identification Number *: _____

Subscriber/Group Number *: _____

Policyholder Signature *: _____ Date Signed: ____/____/____

Note:

For PRIVATE PAY or repackaging the following charges apply:

- Repack - \$6.00
- Over-the-counter – Pharmacy Cost + 35% + \$3.00
- Prescription Drugs – Average Wholesale Price + \$5.00

We will endeavor to match other pharmacy pricing. There may be some wholesale or mail order pharmacies that we cannot match. Prices vary on a daily basis and are subject to change.

**4CARE PHARMACY PRESCRIPTION PURCHASE
TERMS AND CONDITIONS**

4Care Pharmacy ("Seller") provides prescription medications to the patient/resident identified herein as a service pursuant to the request of and at the direction of licensed medical care provider. The prescriptions provided are not manufactured by 4Care Pharmacy.

1. Acceptance of Terms. By accepting a prescription from 4Care Pharmacy, Buyer accepts these terms and conditions.
2. Payment Terms. Buyer agrees to pay the charges for the prescriptions indicated on the invoice or bill for each prescription, plus all sales and local taxes attributed thereto that are previously disclosed in writing. This payment obligation applies to prescriptions from other pharmacies contracted by 4Care to provide prescriptions in certain cases (such as emergencies or the first prescriptions filled after admission) to meet immediate medical needs. Buyer agrees the payment obligations of this Payment of the charges is due and payable upon presentation of a statement. Any amounts not paid when due may hereafter bear a late charge at the rate of 1½ % per month, or the highest rate allowed by applicable law, whichever is lower until paid in full. If authorized by Buyer, charges will be made directly to Buyer's credit card pursuant to authorization provided herein and payment will be governed according to the card issuer agreement applicable to such charge.
3. Warranty. Seller provides the medications "as is", upon reliance of the manufacturer's representations and warranties and pursuant to the request of and instructions of a licensed medical care provider. Seller hereby assigns to Buyer the benefits of all warranties given by any persons from whom Seller purchased the medications.

THE FOREGOING WARRANTIES ARE EXCLUSIVE AND IN LIEU OF ALL OTHER EXPRESS OR IMPLIED WARRANTIES (EXCEPT OF TITLE) FROM SELLER INCLUDING BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE. SELLER SHALL NOT BE SUBJECT TO AND DISCLAIMS: (1) ANY OTHER OBLIGATION OR LIABILITY ARISING OUT OF BREACH OF CONTRACT OR OF WARRANTY; (2) ANY OBLIGATION WHATSOEVER ARISING FROM TORT CLAIMS INCLUDING NEGLIGENCE AND STRICT LIABILITY OR ARISING UNDER THEORIES OF LAW WITH RESPECT TO PRODUCTS SOLD OR SERVICES RENDERED BY SELLER OR ANY UNDERTAKINGS, ACTS OR ADMISSIONS RELATED THERETO; AND (3) ALL CONSEQUENTIAL, INCIDENTAL AND CONTINGENT DAMAGES WHATSOEVER.

4. Severability. If a court of competent jurisdiction or arbitrator finds any term of this agreement to be invalid or unenforceable for any reason as to any person or circumstance, then the terms shall continue in effect only to the extent that it remains valid and the court's findings shall not render the term invalid or unenforceable to any other person or circumstance; and all other terms of this Agreement in all other respects shall remain valid and enforceable.
5. Governing Law and Jurisdiction. This Agreement shall be governed in all respect by the laws of the State of Utah, without regard to Utah choice of law provisions. The parties agree that jurisdiction over and venue in any legal proceeding arising out of or relating to this contract shall be in the state or federal courts in Salt Lake County, Utah.
6. Entire Agreement. These terms and conditions, and any warranties, specifications, or other terms and instructions provided with the prescription ("Agreement"), constitutes the entire Agreement between the patient/resident/and purchaser (collectively "Buyer") and 4Care Pharmacy ("Seller"), and supersedes all prior and contemporaneous oral or written agreements understanding and communications between the Buyer and Seller. Neither party shall be bound by any terms or conditions or representations **not** stated herein. No term of this Agreement shall be amended, supplemented or modified except by a writing signed by the party against whom enforcement is sought.

Pharmacy Notice of Privacy Practices

Effective August 10, 2006

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Patient privacy is important to 4Care Pharmacy ("Pharmacy"). The Pharmacy is required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your right with respect to PHI about you.

The Pharmacy is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Your Health Information Rights

You have the following rights with respect to PHI about you:

1. **Obtain a paper copy of the Notice upon request.** You may request a copy of the Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy from 4Care Pharmacy or you may contact our office to request that a Notice be mailed to you.
2. **Inspect and obtain a copy of PHI.** You have the right to access and copy PHI about you contained in a designated record set for as long as the Pharmacy maintains the PHI. The designated record set will include prescription and billing records. In most cases, 4Care Pharmacy may be able to provide you with a copy of your prescription history. Otherwise, to inspect or obtain a copy of PHI about you, you must send a written request to our office. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to PHI about you, you may request that the denial be reviewed.
3. **Request an amendment of PHI.** If you feel that the PHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must send a written request to our office. You must include a reason that supports your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.
4. **Receive an accounting of disclosures of PHI.** You have the right to receive an accounting of the disclosures we have made of PHI about you on or after September 1, 2006, for most purposes other than treatment, payment or health care operations. The accounting will exclude certain disclosures, such as disclosures made directly to you, disclosures you authorize and disclosures to friends or family members involved in your care. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations. To request an accounting, you must submit a request in writing to our office. Your request must specify the time period for which you wish to obtain an accounting, which may not exceed six years or the length of time your PHI has been lodged with the Pharmacy, whichever is shortest. The first accounting you request within a twelve month period will be provided free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved, if any, and you may choose to withdraw or modify your request at that time.
5. **Request communications of PHI by alternative means or at alternative locations.** You have the right to request to receive communications of PHI from the Pharmacy by alternative means or at an alternative location. For example, you may request that we contact you on a mobile phone number instead of your home number. To request confidential communication of PHI about you, you must submit a request in writing to 4Care Pharmacy. We will accommodate all reasonable requests. In the event of an emergency regarding your treatment, if we cannot reach you promptly using the alternative means or alternative location you requested, we may try to reach you by other means or at another location.
6. **Request a restriction on certain uses and disclosures of PHI.** You have the light to request additional restrictions on our use or disclosure of PHI about you by sending a written request to our office. We are not required to agree to those restrictions.

Examples of How We May Use and Disclose PHI

Subject to applicable state law, the following are descriptions and examples of ways we use and disclose PHI:

1. **We will use PHI for treatment.** For example, information obtained by the pharmacist will be used to dispense prescription medications to you and may be used to monitor the effectiveness, safety and compliance of your drug therapy. In addition, we may contact you to provide refill reminders, transfer-out letters, information about medication management services that we offer, information about treatment alternatives, educational information about current or new therapeutic products and/or other health-related benefits and services that may be of interest to you. Some of these contacts may be sponsored by manufacturers.
2. **We will use PHI for payment.** For example, if you are covered under a prescription plan, we will contact your insurer or pharmacy benefit manager to determine whether it will pay for your prescription and the amount of your co-payment. We will bill you or, if your prescriptions are paid for in whole or in part by a prescription benefit or health plan, the enrolled plan member (employee/retiree) or a third-party payer for the cost of prescription medications dispensed to you. The information on or accompanying the bill may include information that identifies you, as well as the prescriptions you are taking.
3. **We will use PHI for health care operations.** For example, we may use information in your health record to monitor drug usage and inventory levels. This information will be used in an effort to continually improve the quality and effectiveness of the health care and services we provide. For the convenience of our clients the Pharmacy allows spouses and dependents to order and receive services using the enrolled plan member's account. The Pharmacy will direct all account-related information, including information regarding services provided to a spouse or family member, to the enrolled member (employee/retiree). If you currently receive prescriptions through a family member's account, but would like to receive the Pharmacy's communications directly, you must submit a request for confidential communications to our office.

Subject to applicable state law, we also are permitted or required to use or disclose PHI for the following purposes; however, some of these disclosures may never occur at our pharmacy:

1. **Business associates.** We contract with business associates to perform certain services or functions to or on behalf of the Pharmacy. For example, we may contract with a business associate to perform billing services for us. We may disclose PHI about you to our business associates so that they can perform the job we have asked them to perform and to report collected PHI information to us. We require our business associates to appropriately safeguard the PHI.
2. **Communication with individuals involved in your care or payment for your care.** Health professionals such as pharmacists, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care.
3. **Food and Drug Administration (FDA).** We may disclose to the FDA or persons under the jurisdiction of the FDA, PHI relative 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.
4. **Workers' compensation.** We may disclose PHI about you as authorized by and as necessary to comply with laws relating to workers' compensation or similar programs established by law.
5. **Public health.** As required by law, we may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury or disability.
6. **Law Enforcement.** We may disclose PHI about you for law enforcement purposes as required by law or in response to a valid subpoena or other legal process as required by law. We must disclose PHI about you when required to do so by law.
7. **Health oversight activities.** We may disclose PHI about you to an oversight agency for activities authorized by law. These oversight activities include audits, investigations and inspections, as necessary for our licensure, and for the government to monitor the health care system, government programs and compliance with civil rights laws.
8. **Judicial and administrative proceedings.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.
9. **Research.** We may disclose PHI about you to researchers when such research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information. We may contact you to inform you of research opportunities in which you may wish to participate.
10. **Coroners, medical examiners and funeral directors.** We may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to carry out their duties.
11. **Organ or tissue procurement organizations.** Consistent with applicable law, we may disclose PHI about you to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
12. **Fundraising.** We may contact you as part of a fundraising effort.
13. **Notification.** We may use or disclose PHI about you to notify or assist in notifying a family member, personal representative or another person responsible for your care, of your location and your general condition.
14. **Correctional institution.** If you are or become an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.
15. **To avert a serious threat to health or safety.** We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
16. **Military and veterans.** If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate military authority.
17. **National security and intelligence activities.** We may release PHI about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
18. **Protective services for the President and others.** We may disclose PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
19. **Victims of abuse, neglect or domestic violence.** We may disclose PHI about you to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you.

Other Uses and Disclosures of PHI

The Pharmacy will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you, except to the extent that we have already taken action in reliance on the authorization.

For More Information or to Report a Problem

If you have questions or would like additional information about the Pharmacy's privacy practices, you may contact our office by writing to 4Care Pharmacy, Privacy Office, 109 West Gentile Street, Layton, UT 84041-3000 or you may call the office toll-free at 1-877-477-3229. If you believe your privacy rights have been violated, you can file a complaint with our office or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.