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| **Nu Life** | | Instructions & Admission Requirements |
| 1. Forms | Complete and sign prior to transporting and placement of the Client.   1. Enrollment Application 2. Contract for Services (Must be Notarized) 3. Power of Attorney (Must be Notarized) 4. Pharmacy Information Sheet 5. Authorization for Release of Confidential Information 6. Permission for Release of Program Records 7. Consent for Release to Insurance Provider 8. Individual Treatment Plan Input 9. Consent for Treatment & Participation 10. Consent for Medical Treatment 11. Consent for Evaluation 12. Equine Waiver Interstate | |
| 2. Items to Include | Please include the following items with admissions paperwork   1. Recent Picture of Client 2. Copy of Client’s Birth Certificate 3. Copy of last physical exam only if it was within the last three months must be included with paperwork. If this is not included with initial paperwork, Nu Life will arrange for a physical to be performed by a contracted physician within the first seven days of admission. All costs for such medical examinations and/or procedures will be the responsibility of the parent/guardian. 4. One Copy of immunization records 5. One Copy of Insurance Cards, front & back 6. If parents are divorced and one parent has full custody please include copy of court decree granting full custody | |
| 3. Tuition & Fees | Minimum initial payment consisting of the first full month tuition plus the enrollment fee must be brought with the Client at time of placement.    Note: Upon acceptance of Client into the program arrangements can be made for the minimum initial payment to be made prior to transporting the Client to the Nu Life facility. | |
| 4. Other | Included in the admissions forms package.   1. Clothing Inventory | |

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|  | | Enrollment Application | | | | |
| This form is crucial in the assessment of your daughter’s suitability for enrollment in Nu Life.  While we understand it is lengthy and time consuming, its importance can not be stressed enough. | | | | | | |
| **A. Client Information** | | | | | | |
| **Name**  (First Middle Last) | | | Nickname | Age | Date of Birth | Social Security Number |
| Height | Weight | | Eye Color | | | |
| Sex |  | |  | | | |
| Hair Color | Distinguishing Features (Tattoos, Birthmarks, Scars etc.) | | | | | |
| Any Special Physical Needs or Limitations \_\_\_\_ Yes \_\_\_\_ No (If Yes Describe) | | | | | | |
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| Please describe the specific events that led to your decision to enroll yourself: | | | | | | |
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| B. Personal Information | | | |  | | | | | | | | | | | | | | | | | |
| Client | **Client’s Name**  (First Middle Last) | | | | | Occupation | | | | | Date of Birth | | | | Social Security Number | | | | | | |
| Phone & Email | Home | | | | Cell | | | | | | | Fax | | | | | | | | |
| Work | | | | Email Address | | | | | | | | | | | | | | | |
| Address | Street | | | | | | Mailing Address (If different) | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | | | | |
| City | | | State | | Zip | City | | | | | | | | | | State | | | Zip |
| Marital Status | □ Single □ Married □ Divorced □ Widower | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | |  | | | | | | | | | |
| Spouse | **Spouse’s Name** (First Middle Last) | | | | | Occupation | | | | | Date of Birth | | | Social Security Number | | | | | | | |
| Phone & Email | Home | | | | Cell | | | | | | | Fax | | | | | | | | |
| Work | | | | Email Address | | | | | | | | | | | | | | | |
| Address | Street | | | | | | Mailing Address (If different) | | | | | | | | | | | | | |
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| City | | | State | | Zip | City | | | | | | | | | State | | | Zip | |
| Marital Status | □ Single □ Married □ Divorced □ Widow | | | | | | | | | | | | | | | | | | | |
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|  | **Sponsors Name:**(First Middle Last) | | | | | Occupation | | | | Date of Birth | | | | Social Security Number | | | | | | | |
| Phone & Email | | Home | | | Cell | | | | | | Fax | | | | | | | | | |
| Work | | | Email Address | | | | | | | | | | | | | | | |
| Address | | Street | | | | | Mailing Address (If different) | | | | | | | | | | | | | |
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| C. Client’s History |
| Describe your strengths: |
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| Describe your Weaknesses: |
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| Have you ever attempted or discussed suicide? Yes \_\_ No \_\_  If yes, please describe the situation and behaviors: |
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|  |
| Have you demonstrated violence towards yourself, others or property? Yes \_\_ No \_\_  If yes, please describe the situation and behaviors: |
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|  |
| Describe your relationship with your family |
|  |
|  |
| Have you used drugs or alcohol? Yes \_\_\_ No \_\_\_  If yes, describe to the best of your knowledge, the substances, frequency and when use began and last occurred: |
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|  |
| Describe you academic/work performance |
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| **Client History (continued)** |
| Are you sexually active (promiscuity or other inappropriate behaviors)  Yes \_\_\_ No \_\_\_ Unsure \_\_\_  If yes, please explain: |
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| Do you have a history of violence/ victim of violence? Yes \_\_\_ No \_\_\_  If yes, please explain: |
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| Do you have special dietary needs? Yes \_\_\_ No \_\_\_  If yes, please explain: |
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| **D. Past Outpatient Treatment History** | | | | **(**Please list 3 most recent “**OUTPATIENT”** therapeutic placements) | | | |
| Treatment | **Therapist Name** | | Phone Number | | | Dates From: / /  To: / / | |
| Address | Street | | | | | |
|  | | | | | |
| City | | | State | | Zip |
| Outcome  Of  Treatment |  | | | | | |
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| Treatment | **Therapist Name** | | Phone Number | | | Dates From: / /  To: / / | |
| Address | Street | | | | | |
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| City | | | State | | Zip |
| Outcome  Of  Treatment |  | | | | | |
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| Treatment | **Therapist Name** | | Phone Number | | | Dates From: / /  To: / / | |
| Address | Street | | | | | |
|  | | | | | |
| City | | | State | | Zip |
| Outcome  Of  Treatment |  | | | | | |
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| **E. Past Inpatient Treatment History** | | | | **(**Please list 3 most recent “**INPATIENT”** therapeutic placements) | | | |
| Treatment | **Facility Name** | | Phone Number | | | Dates From: / /  To: / / | |
| Address | Street | | | | | |
|  | | | | | |
| City | | | State | | Zip |
| Outcome  Of  Treatment |  | | | | | |
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| Treatment | **Facility Name** | | Phone Number | | | Dates From: / /  To: / / | |
| Address | Street | | | | | |
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| City | | | State | | Zip |
| Outcome  Of  Treatment |  | | | | | |
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| Treatment | **Facility Name** | | Phone Number | | | Dates From: / /  To: / / | |
| Address | Street | | | | | |
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| City | | | State | | Zip |
| Outcome  Of  Treatment |  | | | | | |
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| **F. Medical History** | | | | | | | | |
| 1. Have you had a tetanus inoculation within 10 years? Yes \_\_\_ No \_\_\_ | | | | | | | | |
| 2. Have you ever been hospitalized for any reason? Yes \_\_\_ No \_\_\_  If yes, please explain: | | | | | | | | |
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| 3. Do you have any allergies? Yes \_\_\_ No \_\_\_  If yes, Please explain: | | | | | | | | |
|  | | | | | | | | |
| 4. Do you take birth control pills? Yes \_\_\_ No \_\_\_  If yes, Please indicate which medication and for how long has she been prescribed this medication: | | | | | | | | |
|  | | | | | | | | |
| 5. Have you or any close relatives had any of the following: | | | | | | | | |
| Alcoholism/Addictions | | Yes \_\_\_ No \_\_\_ | If yes, Who?  Describe: | | | | | |
| Mental Illness | | Yes \_\_\_ No \_\_\_ | If yes, Who?  Describe: | | | | | |
| Depression | | Yes \_\_\_ No \_\_\_ | If yes, Who?  Describe: | | | | | |
| Bi-Polar | | Yes \_\_\_ No \_\_\_ | If yes, Who?  Describe: | | | | | |
| Kidney Disease | | Yes \_\_\_ No \_\_\_ | If yes, Who?  Describe: | | | | | |
| Cancer | | Yes \_\_\_ No \_\_\_ | If yes, Who?  Describe: | | | | | |
| Heart Disease | | Yes \_\_\_ No \_\_\_ | If yes, Who?  Describe: | | | | | |
| Tuberculosis | | Yes \_\_\_ No \_\_\_ | If yes, Who?  Describe: | | | | | |
| 6. Please list any medical conditions: | | | | | | | | |
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| **F. Medical History (continued)** | | | | | | | | |
| 6. Have you had any of the following?  Yes \_\_ No \_\_ Anemia Yes \_\_ No \_\_ Measles  Yes \_\_ No \_\_ Arthritis Yes \_\_ No \_\_ Meningitis  Yes \_\_ No \_\_ Asthma Yes \_\_ No \_\_ Migraines  Yes \_\_ No \_\_ Blackouts Yes \_\_ No \_\_ Mononucleosis  Yes \_\_ No \_\_ Bladder or Kidney Infection Yes \_\_ No \_\_ Mumps  Yes \_\_ No \_\_ Bone Condition Yes \_\_ No \_\_ Muscle Weakness  Yes \_\_ No \_\_ Chicken Pox Yes \_\_ No \_\_ Night sweats  Yes \_\_ No \_\_ Cluster Headaches Yes \_\_ No \_\_ Numbness, Tingling  Yes \_\_ No \_\_ Convulsions or Seizures Yes \_\_ No \_\_ Pneumonia/Bronchitis  Yes \_\_ No \_\_ Cramps Yes \_\_ No \_\_ Polio  Yes \_\_ No \_\_ Dermatitis Yes \_\_ No \_\_ Pregnancy  Yes \_\_ No \_\_ Diabetes Yes \_\_ No \_\_ Chronic Diarrhea  Yes \_\_ No \_\_ Eating Disorders Yes \_\_ No \_\_ Chronic Constipation  Yes \_\_ No \_\_ Problems with Sleep Yes \_\_ No \_\_ Rheumatic Fever  Yes \_\_ No \_\_ Epilepsy Yes \_\_ No \_\_ Scarlet Fever  Yes \_\_ No \_\_ Fainting/ Dizziness Yes \_\_ No \_\_ Scoliosis  Yes \_\_ No \_\_ Fatigue Yes \_\_ No \_\_ Stomach Problems  Yes \_\_ No \_\_ Frequent Colds Yes \_\_ No \_\_ Trichotillomania  Yes \_\_ No \_\_ Frequent Ear Infections Yes \_\_ No \_\_ Ulcers  Yes \_\_ No \_\_ German Measles Yes \_\_ No \_\_ Venereal Disease  Yes \_\_ No \_\_ Heart Disorder Yes \_\_ No \_\_ Vision Problems  Yes \_\_ No \_\_ Hepatitis Yes \_\_ No \_\_ Weight Change  Yes \_\_ No \_\_ Herpes Yes \_\_ No \_\_ Whooping Cough  Yes \_\_ No \_\_ High Blood Pressure Yes \_\_ No \_\_ Other:  Yes \_\_ No \_\_ Hyperglycemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes \_\_ No \_\_ Hypoglycemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| If yes to any of the above, Please Explain: | | | | | | | | |
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| **G. Medications – Past and Present** | | | | | | | | |
| 1. Please list all medications you are currently taking. | | | | | | | | |
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| 2. Please List all medications you have been prescribed in the past. | | | | | | | | |
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| **H. Medical Insurance Information** | | | | | | | | |
| Name of Insured | | | | Policy Number | | | Group Number | |
| Name of Insurance Company | | | | | Phone Number | | | |
| Address of Insurance Company | Street | | | | | | | |
|  | | | | | | | |
| City | | | | | State | | Zip |
|  | | | | | | | | |
| **I. Dental Insurance Information** | | | | | | | | |
| Name of Insured | | | | Policy Number | | | Group Number | |
| Name of Insurance Company | | | | | Phone Number | | | |
| Address of Insurance Company | Street | | | | | | | |
|  | | | | | | | |
| City | | | | | State | | Zip |
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| In case Nu Life arranges for refills of your prescription please enclose a copy of both sides of your prescription card. Please understand that Nu Life will make every effort to have your insurance billed for your son/daughters prescription, however, some insurance companies do not cover all pharmacies. This information will be provided to the local pharmacy when a request for a prescription is made. If you have any questions please feel free to contact the office.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_  Signature of Policy Holder Date | | | | | | | | |
| Note 1. Please include a copy of yours Immunization Record **Note 2. Please include a copy of the insurance cards (not the card itself)** | | | | | | | | |

#### NU LIFE

**CONTRACT FOR SERVICES**

**Enrollment Contract** made by, between, and among Nu Life (hereinafter the “Program”), a residential treatment program organized and existing under and by virtue of the laws of the State of Utah with its principal place of business at or near Richfield the undersigned, whether one or more (hereinafter the “Client” or “Sponsors”):

#### Recitals

1. Nu Life owns and operates a facility at or near Richfield, for the purpose of providing rehabilitation and educational services for adults with substance abuse needs.

2. Nu Life is properly licensed by the Utah State Department of Human Services.

3. Client desires to employ Nu Life for purposes of providing rehabilitation and educational services to Client, for the consideration, and subject to the terms contained herein.

#### NOW THEREFORE THIS CONTRACT

1. **ADMISSION OF Client** – Upon the completion of this agreement, the program agrees to review for the admission the above named Client and promises to undertake and provide the following services and facilities; room and board; routine services and testing; all routine therapeutic services; supervised use of recreational equipment and facilities; supervised work projects; admission lab screening; psychiatric consultation; clothing and personal amenities; gym clothing; haircuts; postal costs; telephone calls for therapeutic purposes; and incidental allowance expenditures.

2. **CONTRACT PERIOD** - This agreement will begin on the date Client is physically admitted to Nu Life, and be in effect for a period of 30 days/60 days/ 90 days. This contract shall be renewed automatically on a month to month basis at that time, unless either party terminates this agreement by giving written notice to the other parties outlines in section 8.a. 8.b. All clients accepted on the condition that they will complete individual treatment goals.

1. **FINANCIAL PROVISION** –
2. **ROOM AND BOARD, THERAPY AND TREATMENT CHARGES** - The monthly rate for services described under section 2 shall be $7,290.00 per month to include services listed in section 2 of this contract.
3. **ADDITIONAL COSTS AND EXPENSES** - in addition to the above payment, the Sponsor(s)/Client/Client agree to pay for the following expenses incurred by the Client, which will be billed to the Sponsor(s)/Client/Client monthly as they arise; Major Medical and Dental expenses; prescribed medications; airline or other forms of transportation (including admission and discharge travel expenses); request special or psychological testing beyond that which is normally covered by the Program.
4. **PAYMENT SCHEDULE** - an initial payment consisting of the enrollment fee of $2,000.00 plus the first months costs are due upon admission. All other costs described under 4.b. shall be billed to the Sponsor(s)/Client/Client on a monthly basis along with future costs.
5. **ANNUAL RATE INCREASE** - The rate described under 4.a. shall be subject to annual increase.
6. **RESPONSIBILITY OF DAMAGE TO PROPERTY BY THE CLIENT** - Sponsor(s)/Client/Client agree to be financially responsible for the costs of repairing or replacing any program property or personals, or for the replacement of any property belonging to others which may be located at the facility which has been damaged, defaced or destroyed by the Client, or for any damage resulting from injury to third person caused by the Client.
7. **EXPENSES FOR THE ASSISTANCE IN THE RETURN OF RUNAWAY CLIENTS** - In the event that the Client becomes a run-away, either from Program or elsewhere, the Program will use notify the necessary authority such as courts, police. Sponsors/Client will be responsible for any expenses that will result in the lack of a 30day notice.
8. **RESPONSIBILITY FOR INJURY OR ACCIDENT** - The Program is not liable financially or otherwise, for the loss, damage, or theft of any of the Client’s property during their stay.
9. **COSTS OF COLLECTION: ATTORNEY FEES** - Sponsor(s)/Client agree to pay for the cost of collection of any amounts due under this agreement, including reasonable attorney’s fees at the rate of 35% of the balance assigned plus the court costs. The Sponsor(s)/Client also agree to pay 18% annum on any unpaid balance that becomes over 60 days past due both during the treatment process and if any default occurs.

5. **RESPONSIBILITY FOR INJURY OR ACCIDENT** - The Program is not liable for any injuries, illness or other damages occurring to the Client during the term of enrollment, including any resulting from the Client’s participating (on or off campus) in programs or activities of the Program.

6. **RESPONSIBILITY FOR LOST, STOLEN OR DAMAGED PERSONAL PROPERTY** - The Program is not responsible or liable for any lost, stolen or damaged personal property of the Client during the term of enrollment, including any resulting from the Client’s participating (on or off campus) in programs, liable for any lost, stolen or damaged personal property of the Client which is the result of actions on the part of another Client.

7. **RELEASE OF RECORDS** - The Program shall release the Clients records to other facilities upon the specific request and written authorization for the Sponsor(s)/Client. However said records shall not be released until all balances owing the Program under this contract are paid in full.

8. **CHOICE OF JURISDICTION, LAW, AND OTHER MATTER** - Sponsor(s)/Client agree to be subject to jurisdiction of Utah Courts in any dispute between the parties of this agreement. The parties agree that this agreement constitutes a business transaction in subject to the provisions of Title 78, Chapter 27, Section 24, of the Utah Code Annotated 1953 and as amended. Moreover, the parties agree that Utah law shall govern this agreement. Failure of either party to enforce any term or provision of this agreement shall not constitute or be constructed as a waiver of such term or provision of the right to enforce it. If any provision of this agreement is construed as overbroad as written, the remaining provisions shall remain enforceable according to applicable law.

1. **EARLY ENROLLMENT TERMINATION:**
2. **TERMINATION BY PROGRAM** - The Program reserves the right to terminate this agreement at any time upon seven (7) days advance notice to Sponsor(s)/Client. In the event of such termination by the Program, the Program shall refund any unused portion of tuition paid.
3. **WITHDRAWEL BY SPONSOR(S)/CLIENT** - Sponsor(s)/Client retain the right to terminate the agreement at any time without penalty provided a thirty (30) day advance notice has been given to the facility administrator in writing. In the event that the Sponsor(s)/Client withdraw the client prior to the completion of the treatment without thirty (30) days notice, the Sponsor(s)/Client shall pay the Program one (1) months tuition for the breach of this agreement. The equivalent of one (1) months tuition is considered by the parties of this agreement as a reasonable pre-estimate of the probable loses that would be sustained by the Program in the event of a withdrawal of a client prior to the completion of the treatment plan goals and without a thirty (30) notice. This “loss” amount is not considered by either of the parties to this agreement as a penalty of early withdrawal of the client. Instead, because the cost of such items as contracted staff salaries, incurred debt reduction, staff schedules, inventories, operation expenses, etc., are so difficult or impossible to accurately estimate the one (1) month payment equivalent appears to each of the parties as a reasonable estimate of the Programs losses associated with the early withdrawal of the client. In the event of such withdrawal, Sponsor(s)/Client will not be entitled to a refund of the initial placement fee.

10. **THE UNDERSIGNED AGREE(S)** - that in the event that other healthcare professional providers, including, but not limited to other hospital(s), furnish services to the Client while in the Program, the consent(s), assignment(s), guarantee(s), and release(s), herein above set out apply to other providers and services.

11. **SCOPE AND MEANING OF AGREEMENT** - Sponsor(s)/Client hereby acknowledge that they have read the agreement and that they understand and assent to the provisions. This agreement constitutes the entire agreement between the parties except as may be noted by attached addendum when appropriate.

**IN WITNESS WHERE OF**, The parties have executed this agreement as of the last day set forth below.

**By Nu Life:**

Signature for Nu Life Date Signed

**By Client:**

Signature of sponsor (Client) Date Signed

Signature of sponsor (sponsor) Date Signed

Signature of financial sponsor Date Signed

**Signature & Seal of Notary:**

##### Nu Life

## Pharmacy Information Sheet

Pharmacy

Richfield, Utah

In the event that a prescription is needed for an individual staying at Nu Life the following information will greatly help the pharmacy staff. (Please Print)

Name of the Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth of the Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Client’s current medical insurance have prescription coverage?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the insurance carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the card holder on the insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder identification number/Medicaid number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number of the insurance company (Usually on the back of the insurance card.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all allergies to any medications, prescriptions or over the counter:

Please list all current medications and indicate what it was prescribed for (Over the counter, or prescription.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_We will do our best to process the prescriptions under your insurance; but please understand that some insurance companies do not contract with pharmacies in Utah. **Please enclose a copy of the front and back of the current prescription card(s) to help us serve you better**.

Nu Life

465 West 1600 North, Richfield, UT 84720

Phone: Fax:

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize NU LIFE

[ ] to release to:

[ ] to obtain from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person/Facility/Insurance Company

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address City State Zip Phone Number Fax Number

The requested information to be released shall consist of duplicated records concerning the treatment and/or education on or about: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name

The specific information being requested consists of:

|  |  |  |
| --- | --- | --- |
| [ ] Medical History  [ ] Psychological Eval.  [ ] Discharge Summary  [ ] Medication Information  [ ] Social History | [ ] Diagnosis  [ ] Educational Eval/Testing  [ ] Psychiatric Evaluation  [ ] Immunization Record | [ ] Program Records/Transcript  [ ] Master Treatment Plans/Review  [ ] Verbal Communication with Nu Life Staff  [ ] Aftercare Plan with Recommendations  [ ] Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

This information is to be used for the purpose of:

|  |  |  |
| --- | --- | --- |
| [ ] Follow-up Care  [ ] Insurance Determinations | [ ] Personal Files  [ ] Program Placement | [ ] Treatment at Nu Life  [ ] Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

This authorization may be revoked at any time by the patient. The revoking of this authorization shall not cancel any prior action that has already transpired. Specification of date, event, or condition upon which this consent expires is: (If left blank this consent expires 90 days after the date it is signed.) \_\_\_\_\_\_\_\_\_\_\_

I have read and understand the nature of the authorization. I understand that I may revoke it at any time. I release the hospital, its directors, physicians, and employees and the above named organization and its employees, from any and all liability that may arise from this action whether or not foreseen at present.

I understand that certain medical records (including any alcohol\*, drug abuse information\*, and HIV) may be protected by Federal Laws and Regulations. \*42 U.S.C. 290-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CFR Part 2 for Federal regulations. If I have been tested, diagnosed, or treated for HIV, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment. INITIALS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(IF THIS IS NOT INITIALED, THESE CERTAIN MEDICAL RECORDS CANNOT BE RELEASED).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Patient’s Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Sponsor for Client Date

**PERMISSIONS FOR RELEASE OF PROGRAM RECORDS**

To Principal, Counselors, of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most Recent Program’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Phone # Program Fax #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip

Name of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

The above named Client has enrolled at Nu Life. I hereby request the release of his/her Program records to be sent to Nu Life.

Please include the following:

1. Vocational Records
2. Health records

4. Immunization Records

5. Any Counseling Information

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

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Parent/Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Parent/Guardian Printed Name

## CONSENT FOR RELEASE TO INSURANCE PROVIDER

I request and authorize the clinical representative of Nu Life, Richfield, Utah, to disclose a Copy of application, treatment plan information, individual and group therapy and counseling notes, progress notes, psychiatric assessment, and psychologist assessment, and medication assessment and application to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name/title Organization to which disclosure is made)

For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Client)

This disclosure is made to qualify the above patient to meet requirements of coverage and to obtain program evaluation while attending Nu Life. This consent is subject to written revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon the completion of documented discharge of patient.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated Signature of Sponsor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated Signature of Client/patient

|  |  |  |
| --- | --- | --- |
| **INDIVIDUAL TREATMENT PLAN INPUT** | | |
| Client Name |  | Date |
| Spouse |  |  |
| INDIVIDUAL CARE AND TREATMENT PLANS INCLUDING EDUCATION PLANS are made for each Client. Social, emotional, physical goals are to be included. Please send your input: | | |
| 1. Goal in life I desire for my client: | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
| 2. Goal upon termination at the Program: | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
| 3. Objectives to work toward or problems of my client: | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |

Nu Life

CONSENT FOR TREATMENT AND PARTICIPATION

I/We hereby grant to Nu Life, hereafter referred to as the “Program,” full informed consent, authorization and permission to provide such care, treatment and evaluation, to the Client Date of Birth , as the Program considers to be necessary and appropriate, consistent with the needs of the Client. This shall include consent for securing urgent or emergency medical or dental treatment when, in the opinion of the Program, such treatment is appropriate. Authorization is given for pregnancy testing, drug screening and Tuberculosis testing. The Program is authorized to provide for hospital care and to authorize a physician to perform any procedures that may be deemed medically necessary for the well being of the Client.

I/We further consent for the Program to release confidential medical and mental health information to those agents whose direct responsibility is to determine medical necessity and/or payment of claims. I/We understand that the records may contain diagnosis, treatment and prognosis with respect to physical and mental condition, to include record of alcohol and drug abuse, and/or treatment.

I/We further give informed consent for the Client to participate in all programs and activities of the Program, including, but not limited to, educational or therapeutic programs, work projects, training programs, and various forms of recreation and athletics, except for the following specified programs or activities;

I/We further agree to release the Program, its employee’s and its agent from all liability for any injury to the Client caused by any act or omission on their part in the course of such field trips, activities, and leaves; and to indemnify and hold harmless the Program, its medical staff, its employees and its agents from all claims, costs and losses incurred as the result of any act of the Client while on such field trips, activities and leaves.

I/We consent to the taking of photographs and to videotape for internal identification and therapeutic purposes, as well as for publishing as the primary subject in the Client’s personal parent page, as well as unidentified secondary subject in photographs in peer parent pages.

I/We understand that the use of reasonable restraint and/or confinement may be necessary, if severity of symptoms or behaviors warrant, in order to protect the Client from harming himself/herself or others, or destroying Program property. Should such restraints and/or confinement become necessary during the Client’s admission, I/We understand and agree to indemnify the Program, its employees or agents from any loss due to injury that may occur as a result of such restraint and/or confinement.

\_\_\_\_\_\_\_

(Client) (Social Security Number) (Date)

(Sponsor) (Social Security Number) (Date)

NU LIFE

Consent for Emergency Treatment and/or Emergency Surgery/Dental Care

**Client’s Name:**

**Date of Birth:**

I hereby give to Nu Life, permission, after a careful medical examination, to authorize any emergency treatment, surgery, or examination indicated for the benefit of my health. I understand I will be consulted beforehand, if possible, and that I will be kept appraised of special medical needs.

Furthermore, I also hereby give permission to have the above cleaning, fluoride and x-rays done. I understand that the dentist will bill my insurance (if that information is attached) or bill me directly, and my payment will be made directly to the dentist. I do also grant permission of any emergency dental care that may require anesthesia, either local or general. I understand I will be informed of any special dental needs. I agree that I am ultimately responsible for the payment of the dental care, but would like the insurance information to be provided to the dentist for initial payment.

(Signature Client) (Witness)

(Signature Sponsor) (Date)

(Relationship to Client)

Street Address

City State Zip

Nu Life

Consent for Evaluation

Clients Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Client’s Date of Birth**: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**In order to obtain information for vocational services, we need your permission to conduct an evaluation. Examples of proposed test and their purposes are indicated below. It may not be necessary to give all of these tests. We will not give any tests without your consent.**

|  |  |
| --- | --- |
| Intellectual | **Tests in this area measure a Client’s ability to remember what has been seen, heard and the ability to Solve problems. They also reflect the learning rate and assist in predicting how well a Client will do in Program. Tests such as: Woodcock Johnson-revised: part 1 or Wechsler scales of Intelligence.** |
|  |  |
| Social/Emotional | **Tests in this area assess a Client’s personal independence and social functioning in home, Program, and Community. They also assess behavioral patterns that may adversely affect educational performance. Tests such as: MMPI Minnesota Multi-phasic Personality Inventory, Rorschach, Conners rating scale, Burk’s Behavioral Scale, Sentence Completion, Achenbach, Bender Gestalt, Draw a person, Personal History Inventory or Direct Observation.** |
| Vocational/Transition | **Tests in this area are used to identify career strengths, limitations and interest. They also help to Identify present functioning levels of life skills, habits and attitudes relating to vocational performance. Tests such as: Strong Interest Inventory.** |
| Substance Abuse | **Tests in this area identify levels of substance abuse. Tests such as: Substance Abuse Subtle Screening Inventory.** |
| Other | **Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**This evaluation will be initiated when your written permission is received. You have the right to refuse permission for this**

**Evaluation. All tests will be administered in English. Upon request, you may review or be informed of the results.**

**\_\_\_ I DO NOT authorize the evaluation.**

**\_\_\_ I DO authorize the evaluation.**

**\_\_\_ I Authorize ONLY the following evaluations.**

**\_\_\_ Intellectual**

**\_\_\_ Academic**

**\_\_\_ Social/Emotional**

**\_\_\_ Substance Abuse**

**\_\_\_ Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_**

**(Client Signature) (Date)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_**

**(Sponsor Signature) (Date)**

# Equine Specialist

# *Psychotherapy and Counseling Services*

*Certified Provider of Equine Assisted Psychotherapy*

## Registration and Release Form

*Equine Assisted Growth and Development Activity*

*REGISTRATION:*

*Client/Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_*

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

*City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Medical Conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***CONSENT AND WAIVER OF LIABILITY****:*

*I hereby request that the participant named above be accepted into the equine assisted growth and development program, operated by Equine Specialist. I acknowledge that Equine Specialist has fully explained to me the scope of the equine assisted growth and development program, including the potential for injury which can occur from riding horses, caring for horses or being involved in therapeutic/learning activities that include horses. Because of the potential benefits of the equine assisted program, I hereby waive any claim which I or the client may have against Equine specialist or contract personnel arising out of any injury which the client may sustain while involved in the equine program, unless caused by the willful misconduct or gross negligence of Equine specialist, or contract personnel.*

*The undersigned assumes the unavoidable risks inherent in all horse-related activities, including but not limited to bodily injury and physical harm to horse, rider and spectator. In consideration, therefore, for the privilege of riding and/or working and/or participating in activities around horses of Savvy Services the undersigned does hereby agree to hold harmless and indemnify Savvy Services, Equine Specialist, or contract personnel and further release them from any liability or responsibility for accident, damage, injury or illness to the Undersigned or to any family member or spectator accompanying the Undersigned.* ***I have read this release.***

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature of Client/Participant Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature of Sponsor Date*

**Clothing Inventory**

**Each Client will need the following:**

1. pair of sandals
2. pair of tennis shoes
3. pair of dress shoes
4. pair of socks
5. pair of under wear
6. bras
7. tee shirts (no logos)
8. pair of pajamas
9. pair of P.E. shorts
10. pair of knee length shorts
11. pair of long pants (3 pair must be levi)
12. pair of sweat pants
13. modest dress (includes slip, nylons,etc.)

1 cool to cold weather jacket

1. comforter

**These items are not allowed:**

No clothing or other items that represent or advertise drug or alcohol usage.

No weapons

Please bring only the approved items listed above, all other items will be sent home. We supply all feminine products and other hygiene products.