Vista Counseling Services, LLC

ADMISSION APPLICATION INTRODUCTION

Vista Counseling Services, LLC ("VCS") is a Utah limited liability company providing young adults comprehensive counseling services in Salt Lake City, Utah. VCS looks forward to enrolling your young adult in its well-regarded programs. VCS is confident that you and your young adult will profit from your association with VCS through consistent participation, dedicated compliance and appropriate commitment to treatment plans and integrated comprehensive counseling. Since VCS is regulated by the State of Utah and you and VCS are entering into a long-term legal relationship, VCS requires you and your young adult to complete several documents, entitled collectively **"Admission Application"**. The Admission Application provides critical information about your young adult and defines our legal relationship so it is very important that you provide complete and accurate information about your young adult and that you and your young adult thoroughly read, understand and sign each document, where provided. You will note in the documents that your young adult is referred to as "Client" and you are referred to as "Parent/Guardian." You and your young adult are required to sign each contractual commitment with VCS and initial at the bottom of each page. In any event, you are required to sign the "Guaranty" to ensure VCS that you will pay all obligations associated with your young adult's enrollment with VCS. Please carefully complete each blank on every document since your insurance eligibility, if any, may be contingent on providing VCS accurate and complete information. Additionally, admission of your young adult into the VCS program is contingent on your completing and signing each document, where applicable. Attached is an index of documents with an associated box which you and your young adult can check each time you read and sign a document. The documents are standardized and will not be changed since the documents relate to legal and corporate requirements, independent of our relationship. If you have any questions, please contact Emilia Kotter, VCS Admission Coordinator, telephone no. (801) 746-9889 and e-mail: Emilia@vistatc.com.

Revised December 19, 2017

Vista Counseling Services, LLC

ADMISSIONS APPLICATION INDEX

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

APPLICATION FORM

Date of Admission: _____

Client's Full Legal Name: _____

Address: _____

_____

Date of Birth: _____ Height: _____ Weight: _____

Place of Birth: _____ Eye Color: _____ Hair Color: _____

Natural: _____ Adopted: _____ SS#:_____

Insurance Information

Insurance Company: _____

Telephone Number: _____

Address: _____

_____

Pre-Certification #: _____

Name of Insured: _____ DOB: _____

Social Security #: _____ Group #:_____

Plan Name: _____ Policy #:_____

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

CUSTODIAL PARENT INFORMATION

Parent(s) Name(s):_____

Address: _____
_____
_____

Home Phone: _____ Fax Number: _____

Work Phone: _____ Cell Phone:_____

E-mail Address: _____

Spouse OR Non-Custodial Parent Information

Parent(s) Name(s):_____

Address: _____
_____
_____

Home Phone: _____ Fax Number: _____

Work Phone: _____ Cell Phone:_____

E-mail Address: _____

*Please mail legal document to support custody, i.e., divorce decree or court order that identifies the custodial parent to:

Vista Counseling Services, LLC
1776 South Main Street
SLC, Utah 84115

Emergency Contact Information

Name of Emergency Contact: _____

Address: _____

Email Address: _____

Emergency Contact Phone #: _____ Alternate Phone #:_____

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

CLIENT LEGAL STATUS

Client Name: _____ Date: _____

LEGAL STATUS

Are you a United States citizen? ☐ - Yes ☐ - No

If no, what country or countries are you a citizen of?

Are you a ward of the court? ☐ - Yes- ☐ - No

If yes, please supply a legal document stating your status.

Are you currently on probation? ☐ - Yes ☐ - No

If yes, please supply a legal document stating your status.

Send copy of legal document(s) to:

Vista Counseling Services, LLC
1776 South Main Street
Salt Lake City, UT 84115

_____ _____
Client's Signature Dated

_____ _____
Witness' Signature Dated

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

STATEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES

The following rights, duties and obligations relate solely to your actual participation in Vista Counseling Services, LLC's ("VCS") counseling programs:

- As a client of VCS, you have the right to privacy of your protected health information ("PHI") for both current and closed records. You may request a copy of PHI records according to federal HIPAA policy.

- You have the right to receive in writing any reasons for involuntary termination of services by VCS, and criteria for readmission to the program.

- You have the right to freedom from potential harm or acts of violence to yourself or others.

- You have the responsibility to complete assignments and obey rules of conduct for continued eligibility for VCS services. You have the right to the privileges outlined in your treatment plan for obeying program guidelines.

- You have the right to a statement of service fees and other costs associated with services.

- You have the right to receive, in writing, grievance and compliance procedures.

- You have the right to be free from unlawful discrimination.

- You have the right to be treated with dignity and respect.

- You have the right to communicate by phone or in writing with family, attorney, physician, clergyman, and counselor except when contraindicated as determined by your primary therapist or clinical director, and documented in your treatment plan.

- You have the right to a list of persons restricted from visitation by the courts.

- You have the right to send and receive mail providing that security and general health and safety requirements are met.

- You understand and agree that you will not smoke while enrolled in the VCS program.

- You have a right to a statement of maximum sanctions and consequences, reviewed and approved by the Utah Office of Licensing, Department of Human Services.

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

I have read and understand this statement of rights and responsibilities. I also understand that this document shall be maintained in my client records.

_____ _____
Client's Signature Dated

_____ _____
Parent's or Guardian's Signature Dated

_____ _____
Witness's Signature Dated

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

CLIENT MEDICATION LIST

CLIENT NAME: _____ DATE: _____

MEDICATION LIST/INFO:

MEDICATION	DOSAGE	# OF TIMES/DAY

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

OUTPATIENT TREATMENT AGREEMENT

OUTPATIENT TREATMENT AGREEMENT ("Agreement") entered into the day and year set forth below by and between Vista Counseling Services, LLC ("VCS") and _____ ("Client"), a resident of _____ and _____ ("Parent/Guardian").

RECITALS:

VCS is in the business of providing counseling services (as hereinafter defined) to young adults. Client and his/her Parent/Guardian desire that Client receive counseling services from VCS, all upon the terms and conditions set forth in this Agreement.

In consideration of the following terms, covenants and conditions, VCS, Client and Parent/Guardian agree as follows:

1. **Services.** VCS shall provide, or arrange to provide, the following services to Client ("Services"): a comprehensive treatment plan ("Treatment Plan") individual, group and family therapy; addiction counseling; tracking; independent living skills, nursing supervision and management.

   Additional Services ("Additional Services") which shall be billed separately either by the provider of services, or through VCS, shall include but are not limited to: unanticipated transportation costs.

2. **Program Outline**. As an integral part of a Treatment Plan, the Client shall sign with VCS a Program Outline, which is an outline of expectations for participation in VCS's counseling program which, if breached by Client, will be a basis for termination of participation in the program and this Agreement. The most recent version of the Program Outline applies. If there is a conflict between the Agreement and the Program Outline, the Agreement will control the issue.

3. **Compensation.** Parent/Guardian shall pay VCS the total sum of $57,600.00, consistent with Section 4.c. of this Agreement during the Initial Term (as defined in Section 5) of this Agreement, plus any Additional Services which are received by Client and invoiced by VCS. Services received by the Client after the Initial Term shall be paid to VCS at the then prevailing monthly rate charged by VCS, plus charges for Additional Services. VCS reserves the right to change the cost of Services, after the Initial term.

4. **Financial Provisions:**

   A. **First Monthly Payment**. The first monthly payment of $10,400.00 is due upon signing this Agreement.

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

B. **Payment.** Except for the first month, payment for services to be rendered is due on the first day of each month at the following address: 1122 W South Jordan Parkway Suite B, South Jordan, UT 84095. Client or Parent/Guardian shall pay a late fee of $100.00 for all payments received after the 5th day of the month. Each payment which is not received by the 15th day of the month is delinquent and shall bear interest of 1.5% per month, until paid in full. Payment for Additional Services is due 30 days from the date of the invoice. Each payment for Additional Services, not paid by the due date, shall incur interest of 1.5% per month, until paid. The following is the schedule of monthly payments due:

Month	Payment
1	$10,400
2	$9,400
3	$8,400
4	$7,400
5	$6,400
6	$5,400
7	$4,400
8	$3,400
9	$2,400

C. **Minimum Nine Month Commitment.** Client and Parent/Guardian agree to a nine (9) month commitment to the Treatment Plan for Client which is the initial term ("Initial Term") of this Agreement set forth in Section 5.

D. **Refund Policy**. The Initial Term is the minimum enrollment period with Vista. No money will be refunded for the Initial Term, regardless of whether Services or Additional Services are rendered for each day of the Initial Term. The compensation to Vista for the Initial Term is deemed to be earned upon enrollment of the Client. After the Initial Term, in the event this Agreement is terminated pursuant to Section 6, any money prepaid for Services for days that post-date the date of termination, will be refunded to the pre-paying party, minus any outstanding charges for Additional Services or other miscellaneous charges. Money received by Vista from a Parent(s)' / Guardian(s)' lender will be refunded to the lender on the same basis.

E. **Insurance** Benefits. Vista Counseling Services (VCS) is a community based outpatient program. VCS does not participate on any insurance panels, and does not bill insurance companies or third party carriers for any treatment services. A VCS professional will contact your carrier for authorization to determine if any outpatient coverage may be available. Vista's financial office will provide outpatient dates of service (on a monthly basis) that contain all the pertinent information for you to submit outpatient claims to your insurance carrier. You may elect to download reimbursement forms from your carriers website to submit these dates, or alternatively you may elect to seek the assistance of a specialty billing group / health-care advocate of your choosing. Specialty billing groups have insurance coders on staff to assist you in completing billing matters

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

related to outpatient reimbursements. Our finance office **does not** provide billing advice as this is beyond our scope of expertise.

5. **Term**. The Initial Term of this Agreement commences on the effective date of this Agreement, continuing for a period of 9 months unless sooner terminated under Section 6, of the Agreement. The terms and conditions of this Agreement shall apply to all Services and Additional Services rendered during and after the Initial term. This Agreement shall continue in effect after the Initial Term, on a month to month term, until terminated under Section 6 of this Agreement. The "effective date of this Agreement" shall be the date upon which VCS signs the Agreement following signing by the Parent/Guardian and Client.

6. **Termination.** Either VCS, Client (if an adult), or Parent/Guardian may terminate this Agreement upon written notice to the other party after the Initial Term, which shall be effective thirty (30) days after delivery. VCS arranges for services for the Client which includes acquiring services for which a minimum of a nine (9) month commitment is required. VCS may terminate this Agreement, at any time, by providing notice to the Parent/Guardian upon first occurrence of the following events:

    a. Breach of the Program Outline by Client;

    b. Breach of this Agreement;

    c. Failure to pay a delinquent payment, as defined in Section 4 in the Agreement;

    d. Engaging in any act which physically harms, or creates a substantial likelihood for physically harming, another; and

    e. Engaging in behavior which is a crime under federal, state, or municipal law.

7. **Site for Providing Services**. Counseling services, including group, family and individual therapy will primarily be provided at the following location: 1776 South Main Street, Salt Lake City, UT 84115.

8. **Treatment.** VCS shall review with Parent/Guardian and the Client the Treatment Plan including behavioral and medication therapies. All treatment is voluntary and is based upon diagnosis by licensed professionals. Counseling and therapy will be provided under the care, supervision and direction of licensed professionals. **VCS specifically disclaims promises, agreements, representations or warranties regarding the outcome of services provided to the Client. No VCS representative, employee or agent is authorized to modify or limit this disclaimer**.

9. **Additional Agreements, Consent and Information**. As an integral part of this Agreement and implementation of VCS performing the Services, there are attached to this Agreement various agreements, consents and information on pages 13 through 29 of the Admission Application ("Attachments"), which are incorporated into this Agreement by reference. Each Attachment, in addition to this Agreement, must be entirely completed, originally signed and submitted to VCS

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

by the Parent(s)/Guardian(s) and Client, where appropriate. A brief description of two significant Attachments and the Miscellaneous document is:

a. **Outside Pharmacy**. VCS utilizes the services of an outside pharmacy for filling prescription requirements of the Client. It is the sole responsibility of the Parent(s)/Guardian(s) to make payment arrangements with the pharmacy utilized by VCS. See page 15, Admission Application.

b. **HIPAA Compliance**. VCS is subject to the HIPAA Privacy Requirements which refers collectively to the applicable provisions of the Administrative Simplification of HIPAA-the Health Insurance Portability Accountability Act of 1996 (as codified at 42 U.S.C. Section 1320d-d-8) and any regulations promulgated thereunder, including without limitation, the federal privacy regulations (45 CFR Parts 160 and 164) and the Federal Security Standards (45 CFT Part 142). The Attachment is a notification of the Vista Notice of Privacy Practices and a description of how Protected Health Information may be used. See page 25, Admission Application.

10. **Parent(s)/Guardian(s) Representations**. As an integral inducement to VCS to enter into this Agreement, Parent(s)/Guardian(s) and Client represent and warrant that:

a. All information and documentation provided by the Parent(s)/Guardian(s) when responding to information requests in this Admission Application, including all Attachments and exhibits, is true and accurate as of the effective date of the Agreement and will remain true and accurate during this Agreement unless otherwise communicated in writing to VCS;

b. The Client is either the Parent(s)'/Guardian(s)' natural or legally adopted child, or is Parent(s)'/Guardian(s)' legal ward. The Parent(s)/Guardian(s) completing the Admission Application and signing this Agreement is entitled to the sole physical custody of the Client, unless otherwise specifically indicated by identifying by name and providing contact data of the joint custodial parent's or guardian's name;

c. He, she or they have the requisite mental capacity and legal authority to execute this Agreement; and

d. He, she or they are not under any duress or coercion, are free from undue influence, and voluntarily and knowingly, with the intent to be bound by the terms, sign this Agreement.

11. **Remedies**. During the Initial Term, in the event of a breach by Parent/Guardian or Client, as outlined in Section 6, VCS may declare the entire unpaid balance of Compensation, set forth in Section 3, due and payable by providing Notice to the Client (if an adult) or the Parent/Guardian. Additionally, VCS may pursue any legal or equitable remedy warranted by the facts. Parent/Guardian agrees to pay all costs of Court and reasonable attorneys' fees incurred by VCS enforcing this Agreement both before and after filing suit.

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

12. **Governing Law and Jurisdiction**. This Agreement shall be interpreted according to the laws of the State of Utah, excluding choice of law principles. Parent/Guardian agrees that the sole and exclusive venue for litigation relating to this Agreement is the state or federal court in Salt Lake City, Utah, and for that purpose, irrevocably submits to personal jurisdiction of the courts located in Salt Lake City, Utah.

13. **Entire Agreement.** This Agreement supersedes and replaces all prior agreements between VCS and Client or Parent/Guardian relating to the same subject matter, and is the entire agreement between the parties which may not be modified except in writing, signed by both parties. There are no prior or contemporaneous representations being relied upon by any party which are not contained in this Agreement.

14. **Binding Agreement.** This Agreement shall be binding upon and to the benefit of the heirs, legal and personal representatives, successors, assigns, and insurers, as applicable, of the respective parties to this Agreement, including any entities resulting from the reorganization or consolidation of VCS.

15. **Headings**. The headings used in this Agreement are inserted for reference purposes only and shall not be deemed to limit or affect in any way the meaning or interpretation of any terms of the Agreement.

16. **Severability**. The provisions of this Agreement are severable, and in the event any provision of this Agreement is found to be void, voidable or unenforceable, such void, voidable or unenforceable provisions shall not affect in any way another term, condition or provision of this Agreement.

17. **Waiver**. Any waiver by any party of any breach of this Agreement by another, whether such waiver shall be direct or implied, shall not be construed as a continuing waiver or consent to any subsequent breach of the Agreement.

18. **Notice.** Any notice, required or allowed by a party to this Agreement, shall be in writing and delivered personally or by overnight mail, or by verified facsimile or e-mail transmission, addressed as follows:

    If to VCS: 1776 South Main St.
    Salt Lake City, UT 84115

    If to Parent/Guardian:
    (Parent's/Guardian's current address)

    If to Client: _____
    _____

19. **Joint Liability.** The undersigned Client (if an adult) and Parent/Guardian agrees that each are jointly and severally liable to perform the terms and conditions of this Agreement. Each

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Parent/Guardian must consent to an act unless one Parent/Guardian has been granted sole custody of Client in which case the decision of the sole custodial Parent/Guardian is binding on VCS with respect to the Client.

VCS: _____ Date: _____

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

Client: _____ Date: _____

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

PERSONAL GUARANTY

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and to induce Vista Counseling Services, Inc. ("You"), to provide treatment to my child, I absolutely and unconditionally guarantee the full payment and performance of each and every debt and obligation, of every type and description, (whether at maturity or upon acceleration), that my child may now or at any time in the future owe you, plus interest, attorney's fees and collection costs (when permitted by law), and all other amounts agreed to be paid under Outpatient Treatment Agreement between you and my child ("debt").

APPLICABLE LAW - This agreement is governed by the law of the State of Utah. If any part of this agreement cannot be enforced according to its terms, this fact will not affect the balance of this agreement.

REVOCATION - I agree that this is an absolute and continuing guaranty. This agreement cannot be revoked and will remain in effect until the debt is paid in full. I agree this guaranty will remain binding on me, whether or not there are any debts outstanding, until you have actually received written notice of my revocation or written notice of my death or incompetency.

Notice of revocation or notice of my death or incompetency will not effect my obligations under this guaranty with respect to any debt incurred by my child to you prior to the date of your receiving the notice.

You may, without notice to me: (1) release any person who may be liable for the debt, (2) waive or impair any right you may have against any person who may be liable for the debt, (3) settle or compromise any claim against any person who may be liable for the debt, (4) procure any additional security or persons who agree to be liable for the debt, (5) delay or fail to pursue enforcement of the debt, (6) apply amounts you receive from my child or other persons to payment of the debt in any order you select, (7) make any election with respect to the debt provided by law or any agreement with any person liable for the debt, (8) exercise or fail to exercise any rights you have with respect to the debt, (9) extend new credit to my child, or (10) renew, extend, refinance or modify the debt on any terms agreed to by you (including, but not limited to, changes in the interest rate or in the method, time, place or amount or payment) without affecting my obligation to pay under this guaranty.

I will remain obligated to pay on this guaranty even if any other person who is obligated to pay the debt has such obligation discharged in bankruptcy or otherwise discharged by law. No modification of this agreement is effective unless in writing and signed by you and me.

WAIVER - I waive presentment, demand, protest, notice of dishonor, and notice of acceptance of this guaranty. I also waive, to the extent permitted by law, all notices, all defenses and claims that my child could assert, any right to require you to pursue any remedy or seek payment from any other person before seeking payment under this agreement, and all other defenses to the debt, except payment in full. I agree that I will not exercise or enforce any right of subrogation, contribution or reimbursement

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

against any person liable for the debt or any claim to any collateral for such debt until you have received full payment of the debt. You may without notice to me and without my consent, enter into agreements during the term of the Outpatient Treatment Agreement, from time to time for purposes of creating or continuing the debt. If any payments on the debt are set aside, recovered or required to be returned in the event o f the insolvency, bankruptcy or reorganization, my obligations under this agreement will continue as if such payments had never been made.

REMEDIES - If I fail to keep any promise contained in this agreement you may make this agreement and the debt immediately due and payable. You may use any remedy you have under state or federal law, and you may use any remedy given to you by an agreement. If I die, am declared incompetent, or become insolvent (either because my liabilities exceed my assets or because I am unable to pay my debts as they become due), you may make the debt immediately due and payable.

COLLECTION COSTS - I agree to pay the reasonable costs and expenses you incur to enforce and collect this agreement, including attorney's fees and court costs.

IN WITNESS WHEREOF, I signed my name on this day of, _____ 20___, and by doing so agree to the terms of this guaranty.

Guarantor's Signature: _____

Address: _____

_____

Phone: _____

SSN#: _____

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC
PHARMACY AGREEMENT

Wee Care Pharmacy
1580 West Antelope Dr. #130 A
Layton, UT 84041
Phone: (801) 525-5277
Fax: (801) 525-5279

Vista Counseling Services, LLC ("Vista") contracts with **Wee Care Pharmacy dba Davis Drug** to supply medications to its clients. All co-pays and charges will be billed directly from **Davis Drug** to the parent/guardian of Vista's clients.

Student's Name: _____ Birth Date: _____

Home Address: _____ Phone: _____

City/State/Country: _____ Gender: _____

Father's Name: _____ **Mother's Name**: _____

Address: _____ Address: _____

_____ _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Primary Insurance:

Insured's Name: _____

Group #: _____ Ins Id #: _____

Insurance Company address: _____

Phone Number: _____

*Note: Please provide a copy of the insurance card, front and back.

Pharmacy Fee: $40.00 set-up fee

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

I/we authorize the dispensing of medications for the person named above and agree to pay all Co-pays for such medications and the Pharmacy set-up fee for Pharmaceutical services. I agree to timely make each payment regardless of the pendency of insurance payments, reimbursement or coverage. I agree to comply with the **Davis Drug** policies to the extent that the policies are applicable to me or my child.

_____ _____

Parent Signature: Date:

_____ _____

Parent Signature: Date:

I/we authorize the payment of medication co-pays each month by credit card.

Cardholder Name: _____

Credit Card Type: _____

Credit Card #: _____

Expiration Date: _____

V Code: _____

Billing Zip Code: _____

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

PROGRAM PARTICIPATION

I, _____, voluntarily agree to participate in **Vista Counseling Services, LLC's ("VCS") outpatient program** ("the Program") in its entirety. I further agree in consideration of my participation in the Program to indemnify, and hold harmless VCS from any and all claims that may arise because of my participation in the Program, causes of action, damages, judgments, liens, costs including attorneys' fees and any liability, except for claims, causes of action, damages, judgments, liens and liability proximately caused by VCS' negligent or intentional acts.

_____ _____
Client's Signature Dated

_____ _____
Parent's or Guardian's Signature Dated

_____ _____
VCS Representative's Signature Dated

_____ _____
Witness' Signature Dated

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC
RELEASE OF INFORMATION

Client's Name: _____DOB: _____

I, _____, do hereby give permission for Vista Counseling Services, and its designated employees, to release the confidential Mental Health, Substance Abuse, Psychiatric, Medical, and/or Academic information of the client as defined below.

Mark all applicable:

_X__ Discharge Summary
_X__ Psychiatric Evaluation
_X__ Psychosocial Assessment
_X__ Master Treatment Plan
_X__ Physical
_X__ Immunizations
_X__ Verbal Consultation
___ Other (please specify):_____

The information is sent for the following reason(s):

_X__ Continued Treatment _X__ Academic Planning ___ Other (please specify): _____

Notice to Client and/or Guardian

The authorization is good for one (1) year from the date signed, at which time it shall become null and void. You have a right to revoke this authorization at any time by sending your request, in writing, to VCS via fax or mail. This authorization will cease to be effective on the date Vista receives notification except to the extent that action has already been taken in reliance upon it. A photocopy or facsimile of this release is as valid as an original. Current or future treatment is not conditioned upon you signing this release of information except where disclosure of information is necessary for treatment.

Notice to Recipient of Disclosed Information

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Please release the above identified records to:

Educational Consultant Name(s): **Parent/Guardian Name(s):**

_____ _____

_____ _____

Edu. Consultant Contact Information: **Parent/Guardian Contact Information:**

_____ _____

_____ _____

_____ _____

_____ _____ _____

Parent's/Guardian's Signature Date Relationship to Client
(Not required if Client is an Adult)

_____ _____

Client's Signature Date

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

AUTHORIZATION TO ADMINISTER DRUG-ALCOHOL-TOBACCO SCREENS

I, _____, authorize Vista Counseling Services, LLC, to administer, or cause to be administered through third parties, **random** Drug-Alcohol-Tobacco screens ("Screenings") to myself/my minor child, while I/my child is enrolled in the Vista Counseling Services Outpatient Program. Screenings may include, but are not limited to urinalysis, breathalyzer, and serum toxicology. In the event that the Screenings indicate or recommend further testing, I acknowledge that I/my child may be required to seek diagnostic testing from a third party for which I/my child shall be financially responsible.

_____ _____
Client's Signature Dated

_____ _____
Parent's or Guardian's Signature Dated

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC

ACKNOWLEDGMENT OF ALLOWANCE

I acknowledge and understand that Vista Counseling Services, LLC ("VCS") provides me with a weekly $120.00 allowance. I also acknowledge and understand that accepting this allowance requires meeting program expectations. These requirements include complying with the Program Outline, and overall program participation. After consulting with multiple VCS clients and staff, the following $90.00 budget is suggested.

$50.00 Food
$20.00 Cell phone bill
$20.00 Hygiene/miscellaneous
$30.00 Compliance/participation bonus

I acknowledge and understand that $30.00 of the possible $120.00 is considered a compliance/participation bonus for complying with all rules. It is possible, based upon the structured fines for non-compliance with the Program Outline, that the entire weekly $120.00 allowance is forfeited in which case I must resort to paying living expenses from job wages.

_____ _____
Client's Signature Dated

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC
Automatic Card Billing Authorization

Monthly Payment Schedule:

Month	Payment
1	$10,400
2	$9,400
3	$8,400
4	$7,400
5	$6,400
6	$5,400
7	$4,400
8	$3,400
9	$2,400

Monthly amounts are prorated and the changes of tuition rate occur on the day of the month that corresponds to the admission date.

Mail check to:

Vista Counseling Services, LLC
1122 W South Jordan Parkway, Suite B
South Jordan, UT 84095

Form of Payment

☐ **Credit card** for payment of services on the first of each month – MasterCard, Visa, Discover or American Express

☐ **Check** mailed monthly and needs to be paid to Vista Counseling Services, LLC, 1122 W South Jordan Parkway, Suite B, South Jordan, UT 84095

☐ Yes, I authorize Vista Counseling Services, LLC to charge my payments on the card listed below on the first of each month.

○ Services, Personal Needs Account and Medical Expenses.

Type of Card: ☐ Visa ☐ Master Card ☐ American Express ☐ Discover

_____ _____
Name Student's Name

_____ _____
Name on Credit Card (exactly as printed) Security Code for Credit Card (3 or 4 digit #)

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Card Number	Billing Address for Credit Card
Expiration Date	Student Admit Date
Signature Date	Home Phone
E-mail address for card holder	

This authorization remains valid until the above student no longer attends Vista or until you notify Vista in writing that you are canceling automatic billing. If you need to change credit card numbers, please call Matt Dixon @ (801) 446-6312 and e-mail: billing@vistatc.com.

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

Vista Counseling Services, LLC
NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

Please review this notice carefully

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as "protected health information." This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your protected health information.

As part of your protected health information I keep some specific information in what are called "psychotherapy notes." These notes are kept separate from your health record and are given much higher privacy protection. They contain my impressions about you and details of the psychotherapy conversation I consider to be inappropriate for the health record. They contain information pertinent only to my future work with you. They are not available for your review, or to insurance and managed care companies.

I am required by law to maintain the privacy of protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all protected health information that we maintain at that time, I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in our office, sending a copy to you in the mail upon request or providing one you at your next appointment.

How I May Use and Disclose Health Information About You

-For Treatment: Your protected health information may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members.

-**For Payment**: I may use and disclose protected health information so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine

Parent/Guardian initials: _____

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medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum among of protected health information health information necessary for purposes of collection.

-For Health Care Operations: I may use or disclose, as needed, your protected health information in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your protected health information with third parties that perform various business activities (e.g. billing or typing services). This is allowed only if I have written contract which requires that business to safeguard the privacy of your protected health information.

-Required by Law: There are occasions which require me under law to disclose your protected health information with or without your authorization. Some examples are:

-If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police.

-To the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the Federal privacy requirements.

-If you are at risk of being a serious and imminent threat to the health or safety of a person or the public, I will disclose information to prevent or lessen that serious threat. I will disclose it to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

-If there is suspicion of neglect or abuse of a child in the past, present or future I am required by law to report that the Utah Division of Child and Family Services or the police.

-If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Utah Adult Protective Services or the nearest law enforcement agency as soon as I become aware of the situation.

-Utah law requires that I report the names of any individuals having communicable diseases to the Health Department.

-I may disclose your personal health information in accordance with workers compensation laws.

-If you become involved in the court system a judge can order that I provide information on you. Two examples of this are child custody cases and cases in which clients bring action against therapists.

With Your Verbal Permission: I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about who you want us to tell what information about your condition or treatment. You can tell us what you want and we will honor your wishes as long as it is not against the law.

If it is an emergency-so I cannot ask if you disagree-I can share information if I believe that it is what you would have wanted and if I believe it will help you if I do share it. If I do share information, in an

Parent/Guardian initials: _____

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emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

With Your Written Authorization: Uses and disclosures not specifically permitted by the circumstances described above will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your Protected Health Information. You have the following rights regarding protected health information I maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, (name, address and phone number of the Privacy Officer).

-**Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy protected health information that may be used to make decisions about your care. Your right to inspect and copy protected health information will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.

-**Right to Amend.** If you feel that the protected health information I have about you is incorrect or incomplete, you may ask me to amend the information although I am are not required to agree to the amendment.

-**Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your protected health information. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

-Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your protected health information for treatment, payment or health care operations. I am not required to agree to your request.

-**Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. For instance, you can ask me to avoid calling you on selected phone numbers or ask that I send bills to an alternate address.

-**Right to a Copy of the Notice. You have the right to a copy of this notice.**

Complaints

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, (name, address and phone number of the Privacy Officer), or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 202-619-0257. I will not retaliate against you for filing a complaint.

Effective Date

The effective date of this Notice is April 14, 2003.

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____

RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client Name: _____ SS#:_____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Vista Counseling Services Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Vista Counseling Services at the above address.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent/Guardian or Personal Representative Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc…)

PATIENT/CLIENT REFUSES TO ACKNOWLEDGE RECEIPT

_____ _____
Signature of Staff Member Date

Parent/Guardian initials: _____

Parent/Guardian initials: _____

Client initials: _____