Welcome to Renaissance Ranch!

We welcome the opportunity to be a stepping-stone on your path to spiritual, mental, emotional, and physical well-being. You are now part of a community dedicated to recovery, with its foundation resting on a Faith Based approach and its true principles and tenets.

This is your journey and we are here to assist you in any manner feasible. However, we cannot, and will not, do the work for you. It is up to you and your desire for sobriety, peace, joy, serenity and happiness.

The attached packet will help introduce you to Renaissance Ranch. The program rules and policies along with accompanying intake forms were all developed to give us a better understanding of your current situation. Please read them carefully as you will be asked to abide by them. We believe in individualized treatment at Renaissance Ranch so this information is very vital to your program. Please be as honest and accurate as possible.

You will meet with a counselor to discuss and sign your completed paperwork. They will schedule a time to meet and do a more formal assessment of your situation. You will then decide, together, what best fits their professional opinion and your desire for recovery. The two of you will then construct a detailed treatment plan that will be your map and guide throughout your treatment at Renaissance Ranch.

Once again, we welcome you to Renaissance Ranch. We look forward to the endless possibilities that can occur within your life and this program. If you have any additional questions regarding the program, please feel free to contact us (435)703-9840.

Sincerely,
Renaissance Ranch Staff

120 W 1470 S Suite 100, St George UT 84770

RENAISSANCE RANCH
ADDICTION TREATMENT CENTERS

New Client Application

Admission Date: _____

Full Legal Name: _____ _____ _____
Last Middle First

Address: _____ _____ _____ _____
Street City State Zip Code

Phone: _____ _____ _____
Home Work Cell

Email address _____

Date of Birth: ____ ____ _____ SS #: _____ ___ _____

Ethnicity_____ Religious Preference _____

Referred by: _____ _____ _____
Name Agency Phone

Emergency Information: _____ _____ _____
Name Relationship Phone

Medical Conditions: please list in detail:

1. _____ 2. _____

Prescribed Medications:

1. _____ 2. _____
3. _____ 4. _____

_____ _____
Print Name Date

_____
Signature

120 W 1470 S Suite 100, St George UT 84770

Consent for Release of Information

I, _____ am requesting substance abuse treatment services from Renaissance Ranch (RR), a privately funded treatment program, espousing Spiritual-Centered Principles of Recovery, and those found primarily in working the 12 step (AA/NA) recovery process. I recognize the need to freely accept the need to provide private information about myself to include: my social security number, private financial information, previous treatment services, the scope of my patterns of alcohol/other drug (AOD) use and how that use may have affected significant others within my circle of influence, etc. I recognize I may be required to share with those financially responsible for my treatment services all the above and more in regard to my treatment at RR.

This information will be disclosed for the following purposes:

1. To assist with referring me to appropriate types of care and guiding my treatment and recovery support at RR or elsewhere deemed necessary for my continued recovery
2. To be entered into a common database, BestNotes, and/or other Electronic Health Record Contractor
3. To process payment of costs for my treatment and recovery support
4. For monitoring compliance of RR's treatment program and its affiliates
5. *For program audit, survey, and/or research including independent reviewers, contract monitors or researchers appointment by outside stakeholder(s)*

Furthermore, I authorize the disclosure of personal substance abuse treatment and recovery outcomes data collected by contracted substance abuse treatment providers, health care payors, Elevated Billing Services, independently contracted RSS treatment providers in affiliation with RR, Aspen Hills Diagnostics LLC, Red Rock Laboratory LLC. (Initials _____)

Informed and Voluntary Consent for Treatment

The purpose of my participation, as a client, at RR is to acquire knowledge, skills, and attitudes supportive of a sober and more satisfying lifestyle. In addition to the potential positive outcomes likely to occur as a result of my active participation, the following reasonably foreseen risks may occur, as they would in any other AOD treatment program:

- Breach of confidentiality
- Negative reactions of group members/peers
- Emotional stress from treatment requirements
- Self-disclosure
- Stress to relationships resulting from open discussion of issues
- Reminders of past trauma
- Secondary trauma
- Stress to relationships resulting from behavioral changes, positive and negative
- Need to attend 12 step or other recovery support meetings
- Spend time in group and/or working program of recovery
- Urinalysis Testing/Breathalyzer Testing which may require observation by approved staff

Providers will take steps to minimize or protect participants against potential risks by adhering to standards of confidentiality found both in Federal and State Code, and by informing and verifying client understanding of group rules. And by intervening in and guiding appropriate disclosure, confrontation and resolution in group and family conflict. Providers will assist clients in accessing sober support services and self-help groups where acceptance and stress reducing support is available. (Initials _____)

120 W 1470 S Suite 100, St George UT 84770

Client Rights

Each Renaissance Ranch client has the right to:

1. Be treated with love, dignity, acceptance and respect by Staff and other clients.
2. Be fully informed of his/her rights.
3. Be fully informed of any changes or fees associated with Renaissance Ranch.
4. Be involved as much as possible in his/her own treatment plan.
5. Be informed of the treatment process and expectations prior to admittance.
6. Refuse treatment and be informed of any medical, clinical or legal consequences.
7. Refuse to be involved in any experimental research or treatment.
8. Be given advance notice to any pending discharge and reasons thereof.
9. Be free of intentional mental or physical abuse as well as chemical or physical restraint (except when endangering self or others).
10. Be assured that any information contained in his/her record will not be released to any outside agency(s) or individual(s), except for affiliated professionals who assist in providing services, without the client's written authorization.
11. Be fully informed of his/her legal, medical and clinical status.
12. Examine his/her file to the extent permitted by Renaissance Ranch policy and with a Counselor present.
13. Receive equal treatment and opportunity regardless of race, color, creed, religion, handicap, disability, etc.
14. Voice grievances directly to management, counselor or other Renaissance Ranch staff without fear of reprisal.
15. Be given a copy of his/her rights if requested.
16. Be given reasons for involuntary termination, an opportunity to state their view and the criteria for readmission into the program.
17. Be protected from harm or acts of violence.
18. Be insured that the rights of smokers and non-smokers comply with the Clean Air Act.

Clients are encouraged to report any offenses to these rights to the Executive Director.

32-725-12. Clients' Rights. Utah Code

(1) Written clients' rights shall be established and made available to the client, guardian, next of kin, sponsoring agency, representative payee, and the public.(2) Agency policy may determine how clients' rights information R4n is distributed.(3) The agency shall insure that each client receiving services has the following rights:

(a) To be fully informed of these rights and all rules governing client conduct, as evidenced by documentation in the clinical record;

(b) To be fully informed of services and related charges for which the client or a private insurer may be responsible, and to be informed of all changes in charges;

(c) To be free of mental abuse, physical abuse and/or exploitation;

(d) To be afforded the opportunity to participate in the planning of personal care services, including referral to health care institutions or other agencies, and to refuse to participate in experimental research;

(e) To be assured confidential treatment of personal records, and to approve or refuse their release to any individual outside the agency, except in the case of transfer to another agency or health facility, or as required by law or third-party payment contract;

(f) To be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs;

(g) To be assured that personnel who provide care demonstrate competency through education and experience to carry out the services for which they are responsible;

(h) To receive proper identification from the individual providing personal care services;

(i) To receive information concerning the procedures to follow to voice complaints about services being performed.

Client Signature Date

120 W 1470 S Suite 100, St George UT 84770

Program Rules and Contract

As a client of Renaissance Ranch Treatment Program I agree to the following:

1. I am aware that these are the minimal requirements for treatment at Renaissance Ranch. Additional expectations may be put into place when clinically appropriate
2. Renaissance Ranch reserves the right to drug test all clients at any time which also may be observed by staff. I will drug test on the randomly selected days without exception. Missed or diluted UA's are considered positive and may result in discharge
3. If I miss a scheduled UA (Mon- Thurs), I will be called in for a random UA on weekends. I will call into my Recovery Coach daily to verify weekend days and times. If weekend UA is missed it will be considered an unexcused absence
4. If I do not initial and date my UA Requisition form it will be considered a "missed" UA, resulting in a weekend UA
5. I will **NOT** engage in any inappropriate physical or sexual contact and or relationships with another client or staff member while enrolled in Renaissance Ranch program
6. To have my personal belongings searched for contraband, weapons, drugs, etc. To not possess guns, blades longer than two inches, other weapons or contraband on site.
7. No smoking or chewing is allowed inside facility. This includes Vaping and E-Cigarettes! Smoking is allowed in designated smoking area outside. Please dispose of cigarette butts appropriately.
8. I will be honest, willing, and open-minded about my recovery, and I will not keep secrets. I will report another client's violation(S).
9. I will complete treatment work and assignments in depth, and on time. I will comply with reasonable staff instructions.
10. I agree to attached "Attendance Policy".
11. I agree to attached "Group Standards".
12. Staff reserves the right to discharge the client at any time.

120 W 1470 S Suite 100, St George UT 84770

Group Standards

- I will keep group confidentiality
- I will wear appropriate attire to group
- I will bring needed materials to group
- I will not use profanity or vulgarity in public and common areas and to use respectful language everywhere
- To stay active and engaged in the group process, and my own recovery process. This includes openly discussing my recovery issues, making progress towards recovery, as well as giving/receiving feedback
- I will identify my own issues and triggers that lead to my compulsive behavior and discuss them in group and with my therapist

Attendance Policy

- If I am going to miss group for any reason I will call (not text) my Therapist to let them know
- Therapist must approve all excused or unexcused absences
- If I call my Therapist because I am sick, and will be missing group, I will come to Renaissance Ranch facility to drug test on that day, or bring an official Dr.'s note on Dr.'s office letter head to my Therapist
- I will be on time for group. As well as scheduled sessions with Therapists, Staff, and or Recovery coach
- I will give at least a 3-day notice to my Therapist if I need to miss group for any reason. This will be considered an excused, IF APPROVED. Anything less than 3 days' notice will be considered an unexcused absence
- 3 (IOP) or more unexcused absences in a month will result in discharge. 2 (GOP) or more unexcused absences in a month will result in discharge, with a possible probationary time to re-enter the program
- If I choose to leave during group session, I will not leave the premises. If I do leave the premises or do not return back to the group, it will result in an unexcused absence
- I will attend 90 meetings in 90 days, at the start of DAY TX/IOP. For GOP I will attend 4 meetings per week. Group will count as my meeting during the week. You cannot count 2 in one day. These must be official 12 step substance abuse meetings. Informal meetings will not be considered unless prior approval from staff is obtained

Client Print name _____

Client _____ **Signature**

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Client Med-Agreement

It is our goal to offer a holistic (mind, body, spirit) solution to addiction. While our experience dictates that complete abstinence is crucial to engaging fully in Recovery, it's important to recognize that we are not medically trained physicians and cannot, make suggestions to any client that is contrary to the advice of a medically trained prescribing physician. However, Renaissance Ranch does require a release of information be signed that we might inform and consult with prescribing physicians to assure that a client's physical diagnosis, goals, and treatment are congruent with their overall goals for treatment with Renaissance Ranch. Renaissance Ranch may also require the client to receive a consultation from a third party physician.

Above client agrees to:

1. Inform Renaissance Ranch of any prescription medications that they are currently taking or currently prescribed.
2. Sign Release of Information (Attached) to allow for Renaissance Ranch and prescribing physician(s) to consult.
3. When medically supported: be off all prescribed narcotics within (30) days of admit date. Otherwise take medication as prescribed.
4. Present sober and understand that if client presents as impaired client may be instructed to not participate in group counseling, or instructed to leave the premises altogether, until level of impairment is appropriate for treatment setting. If level of impairment is assessed to be contradictory to client's growth in Intensive Treatment, client may be referred to another level of care and discharged.
5. Not bring any medications on Renaissance Ranch property.

Date of RX	Medication	Dose	How Often	Reason	Prescriber

Client Print Name: _____

Client Signature: _____

Date: _____

120 W 1470 S Suite 100, St George UT 84770

Consent to Services

I, _____, authorize Renaissance Ranch to provide addictions treatment/mental health services according to the rules and regulations of Renaissance Ranch. These services will be coordinated between the client and the appropriate Renaissance Ranch staff.

I consent to possible searches of my personal belongings by authorized staff whenever conducted, announced or unannounced. I further agree to participate in blood, urine, Breathalyzer or other alcohol or drug tests whenever asked by authorized staff. To ensure the fidelity to treatment support protocols, I understand and agree with the necessity to submit to and allow for observed UA's when requested by staff.

I consent to have my photograph taken. I understand such photograph will be used only for the purposes of identification by authorized staff and will become part of my client file, subject to all applicable confidentiality laws.

Further, I give permission to Renaissance Ranch staff to release my information to all service related vendors, such as our Attending Physician, billing agents, and drug testing company.

Client Signature_____ Date_____

Staff Signature _____ Date_____

120 W 1470 S Suite 100, St George UT 84770

For all participants, please read this:

RELEASE OF LIABILITY

I, _____, acknowledge that I wish, or I wish to participate in Renaissance Ranch activities, which may be conducted on or off campus. I understand that by in participating in these activities I will be using facilities where many hazards may exist and I am aware of the risks that may result. I assume all risk of any injury that may occur to during the program. _____ **Initials**.

In consideration for being permitted to participate in events, I agree to not sue, to assume all risks, and to release and hold harmless Renaissance Ranch and any and all of its predecessors, successors, officers, directors, trustees, insurers, employees, managers, agents, administrators, heirs, attorneys, executors, assigns and/or related or affiliated business entities including, but not limited to Renaissance Ranch Addiction Treatment Center (collectively all of the above persons and entities shall be referred to as the "Released Parties" hereafter) who, through negligence, carelessness or any other cause, might otherwise be liable to me.

I intend by this Release to release, in advance, and to waive my rights and discharge each and every one of the Released Parties, from any and all claims for damages for death, personal injury or other consequence resulting from my participation in this program. I understand and agree that this Release is binding on my heirs, assigns and legal representatives and that the Released Parties shall be exempt from liability to myself, my heirs, assigns and legal representatives.

The undersigned have carefully read this Release and fully understand its contents. The undersigned certify that the undersigned Person is at least 18 years of age. The undersigned are aware that this is a **RELEASE OF LIABILITY, COVENANT NOT TO SUE** and a contract between the undersigned and the persons and entities mentioned above and all of their respective officers, directors, employees, agents and representatives and the undersigned sign it of their own free will.

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician or dentist and performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

☐ Check here if no blood transfusion or blood products are to be given. **Initials:** _____

THIS IS AN IMPORTANT LEGAL DOCUMENT.
READ IT CAREFULLY BEFORE SIGNING BELOW.

_____
PRINT NAME

_____
SIGNATURE

DATE_____

120 W 1470 S Suite 100, St George UT 84770

RENAISSANCE RANCH
ADDICTION TREATMENT CENTERS

AUTHORIZATION TO RELEASE INFORMATION

I, _____DOB_____, hereby authorize that Renaissance Ranch to **DISCLOSE OR OBTAIN** (Please INITIAL highlighted areas) information to or from the following person or organization:

Name _____ *(Emergency Contact/Significant Other)*

Address _____

City, ST, Zip _____

Phone _____e-mail address_____

INFORMATION TO BE DISCLOSED

Initial highlighted areas for each of the following and provide additional information as needed.

____Yes ____No Alcohol and or Drug treatment_____
____Yes ____No Evaluation/Assessment (provide type) _____
____Yes ____No Electronic Health Record information_____
____Yes ____No Psychiatric/Therapeutic treatment services_____
____Yes ____No Laboratory Results_____
____Yes ____No Verbal/Electronic/Mail Communication_____
____Yes ____No Emergency Contact Number (if different from above) _____

PURPOSE FOR DISCLOSURE

____Ongoing treatment services ____Transfer of care
____Coordination of care with provider ____Coordination of care with Significant Other(s)
____Development of Treatment/Crisis Plan ____Emergency contact
____Other (please specify) _____

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released and have the right to revoke this authorization at any time. I understand that I may review the Notices of Privacy Practices before I sign this form and may receive a copy at any time.

_____ _____
Client Signature Date

_____ _____
Witness Date

This authorization is effective until_____ (Date not to exceed 1 year)

For Person/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2) and Health Insurance Portability and Accountability Act (HIPAA). The Federal rules prohibit you from making any further disclosure of this information unless further disclosures 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.

120 W 1470 S Suite 100, St George UT 84770

RENAISSANCE RANCH
ADDICTION TREATMENT CENTERS

AUTHORIZATION TO RELEASE INFORMATION

I, _____DOB_____, hereby authorize that Renaissance Ranch to **DISCLOSE OR OBTAIN** (Please INITIAL highlighted areas) information to or from the following person or organization:

Name	Aspen Hills Diagnostics, LLC
Address	1098 W South Jordan Pkwy Ste 108
City, ST, Zip	Salt Lake City UT 84095-9366
Phone/Fax	801-822-9281

INFORMATION TO BE DISCLOSED

Initial highlighted areas for each of the following and provide additional information as needed.

____Yes ____No Alcohol and or Drug treatment_____
____Yes ____No Evaluation/Assessment (provide type) _____
____Yes ____No Electronic Health Record information_____
____Yes ____No Psychiatric/Therapeutic treatment services_____
____Yes ____No Laboratory Results_____
____Yes ____No Verbal/Electronic/Mail Communication_____
____Yes ____No Emergency Contact Number (if different from above) _____

PURPOSE FOR DISCLOSURE

____Ongoing treatment services ____Transfer of care
____Coordination of care with provider ____Coordination of care with Significant Other(s)
____Development of Treatment/Crisis Plan ____Emergency contact
____Other (please specify) _____

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released and have the right to revoke this authorization at any time. I understand that I may review the Notices of Privacy Practices before I sign this form and may receive a copy at any time. Disclosure: Double Decker LLC has ownership in Aspen Hills Diagnostic, LLC. RR clients are welcome to choose another Laboratory for drug testing services.

_____ _____
Client Signature Date

_____ _____
Witness Date

This authorization is effective until_____ (Date not to exceed 1 year)

For Person/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2) and Health Insurance Portability and Accountability Act (HIPAA). The Federal rules prohibit you from making any further disclosure of this information unless further disclosures 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.

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RENAISSANCE RANCH
ADDICTION TREATMENT CENTERS

AUTHORIZATION TO RELEASE INFORMATION

I, _____DOB_____, hereby authorize that Renaissance Ranch to **DISCLOSE OR OBTAIN** (Please INITIAL highlighted areas) information to or from the following person or organization:

Name	Red Rock Laboratory, LLC
Address	120 W 1470 S Ste 200
City, ST, Zip	St George UT 84770
Phone/Fax	801-916-1881

INFORMATION TO BE DISCLOSED

Initial highlighted areas for each of the following and provide additional information as needed.

____Yes ____No Alcohol and or Drug treatment_____
____Yes ____No Evaluation/Assessment (provide type) _____
____Yes ____No Electronic Health Record information_____
____Yes ____No Psychiatric/Therapeutic treatment services_____
____Yes ____No Laboratory Results_____
____Yes ____No Verbal/Electronic/Mail Communication_____
____Yes ____No Emergency Contact Number (if different from above) _____

PURPOSE FOR DISCLOSURE

____Ongoing treatment services ____Transfer of care
____Coordination of care with provider ____Coordination of care with Significant Other(s)
____Development of Treatment/Crisis Plan ____Emergency contact
____Other (please specify) _____

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released and have the right to revoke this authorization at any time. I understand that I may review the Notices of Privacy Practices before I sign this form and may receive a copy at any time. Disclosure: Double Decker LLC has ownership in Red Rock Laboratory, LLC. RR clients are welcome to choose another Laboratory for drug testing services.

_____ _____
Client Signature Date

_____ _____
Witness Date

This authorization is effective until_____ (Date not to exceed 1 year)

For Person/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2) and Health Insurance Portability and Accountability Act (HIPAA). The Federal rules prohibit you from making any further disclosure of this information unless further disclosures 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.

RENAISSANCE RANCH
ADDICTION TREATMENT CENTERS

AUTHORIZATION TO RELEASE INFORMATION

I, _____DOB_____, hereby authorize that Renaissance Ranch to **DISCLOSE OR OBTAIN** (Please circle specific action) information to or from the following person or organization:

Name	Lisa Stoddard, APRN
Address	437 S Bluff St Ste 202
City, ST, Zip	St George UT 84770
Phone	(435)703-9647

INFORMATION TO BE DISCLOSED

Initial highlighted areas for each of the following and provide additional information as needed.

____Yes ____No Alcohol and or Drug treatment_____
____Yes ____No Evaluation/Assessment (provide type) _____
____Yes ____No Electronic Health Record information_____
____Yes ____No Psychiatric/Therapeutic treatment services_____
____Yes ____No Laboratory Results_____
____Yes ____No Verbal/Electronic/Mail Communication_____
____Yes ____No Emergency Contact Number (if different from above) _____

PURPOSE FOR DISCLOSURE

____Ongoing treatment services ____Transfer of care
____Coordination of care with provider ____Coordination of care with Significant Other(s)
____Development of Treatment/Crisis Plan ____Emergency contact
____Other (please specify) _____

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released and have the right to revoke this authorization at any time. I understand that I may review the Notices of Privacy Practices before I sign this form and may receive a copy at any time.

_____ _____
Client Signature Date

_____ _____
Witness Date

This authorization is effective until_____ (Date not to exceed 1 year)

For Person/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2) and Health Insurance Portability and Accountability Act (HIPAA). The Federal rules prohibit you from making any further disclosure of this information unless further disclosures 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.

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RENAISSANCE RANCH
ADDICTION TREATMENT CENTERS

AUTHORIZATION TO RELEASE INFORMATION

I, _____DOB_____, hereby authorize that Renaissance Ranch to **DISCLOSE OR OBTAIN** (Please circle specific action) information to or from the following person or organization:

Name _____

Address _____

City, ST, Zip _____

Phone _____ Fax _____

INFORMATION TO BE DISCLOSED

Initial highlighted areas for each of the following and provide additional information as needed.

____Yes ____No Alcohol and or Drug treatment_____
____Yes ____No Evaluation/Assessment (provide type) _____
____Yes ____No Electronic Health Record information_____
____Yes ____No Psychiatric/Therapeutic treatment services_____
____Yes ____No Laboratory Results_____
____Yes ____No Verbal/Electronic/Mail Communication_____
____Yes ____No Treatment Regiment/Medication Regiment _____

PURPOSE FOR DISCLOSURE

____Ongoing treatment services ____Transfer of care
____Coordination of care with provider ____Coordination of care with Significant Other(s)
____Development of Treatment/Crisis Plan ____Emergency contact
____Other (please specify) _____

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released and have the right to revoke this authorization at any time. I understand that I may review the Notices of Privacy Practices before I sign this form and may receive a copy at any time.

_____ _____
Client Signature Date

_____ _____
Witness Date

This authorization is effective until_____ (Date not to exceed 1 year)

For Person/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2) and Health Insurance Portability and Accountability Act (HIPAA). The Federal rules prohibit you from making any further disclosure of this information unless further disclosures 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.

120 W 1470 S Suite 100, St George UT 84770

RENAISSANCE RANCH
ADDICTION TREATMENT CENTERS

AUTHORIZATION TO RELEASE INFORMATION

I, _____DOB_____, hereby authorize that Renaissance Ranch to **DISCLOSE OR OBTAIN** (Please circle specific action) information to or from the following person or organization:

Name _____ *(Previous Treatment Provider)*

Address _____

City, ST, Zip _____

Phone _____ Fax _____

INFORMATION TO BE DISCLOSED

Initial highlighted areas for each of the following and provide additional information as needed.

____Yes ____No Alcohol and or Drug treatment_____
____Yes ____No Evaluation/Assessment (provide type) _____
____Yes ____No Electronic Health Record information_____
____Yes ____No Psychiatric/Therapeutic treatment services_____
____Yes ____No Laboratory Results_____
____Yes ____No Verbal/Electronic/Mail Communication_____
____Yes ____No Discharge Summary

PURPOSE FOR DISCLOSURE

____Ongoing treatment services ____Transfer of care
____Coordination of care with provider ____Coordination of care with Significant Other(s)
____Development of Treatment/Crisis Plan ____Emergency contact
____Other (please specify) _____

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released and have the right to revoke this authorization at any time. I understand that I may review the Notices of Privacy Practices before I sign this form and may receive a copy at any time.

_____ _____
Client Signature Date

_____ _____
Witness Date

This authorization is effective until_____ (Date not to exceed 1 year)

For Person/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2) and Health Insurance Portability and Accountability Act (HIPAA). The Federal rules prohibit you from making any further disclosure of this information unless further disclosures 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.

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RENAISSANCE RANCH
ADDICTION TREATMENT CENTERS

AUTHORIZATION TO RELEASE INFORMATION

I, _____DOB_____, hereby authorize that Renaissance Ranch to **DISCLOSE OR OBTAIN** (Please circle specific action) information to or from the following person or organization:

Name	Elevated Billing Solutions, LLC
Address	10542 S Jordan Gateway
City, ST, Zip	South Jordan, UT 84095
Phone/Fax	801-266-1280/ 801-266-3365

INFORMATION TO BE DISCLOSED

Initial highlighted areas for each of the following and provide additional information as needed.

____Yes ____No Alcohol and or Drug treatment_____
____Yes ____No Evaluation/Assessment (provide type) _____
____Yes ____No Electronic Health Record information_____
____Yes ____No Psychiatric/Therapeutic treatment services_____
____Yes ____No Laboratory Results_____
____Yes ____No Verbal/Electronic/Mail Communication_____
____Yes ____No Emergency Contact Number (if different from above) _____

PURPOSE FOR DISCLOSURE

____Ongoing treatment services ____Transfer of care
____Coordination of care with provider ____Coordination of care with Significant Other(s)
____Development of Treatment/Crisis Plan ____Emergency contact
____Other (please specify) _____

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released and have the right to revoke this authorization at any time. I understand that I may review the Notices of Privacy Practices before I sign this form and may receive a copy at any time.

_____ _____
Client Signature Date

_____ _____
Witness Date

This authorization is effective until_____ (Date not to exceed 1 year)

For Person/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2) and Health Insurance Portability and Accountability Act (HIPAA). The Federal rules prohibit you from making any further disclosure of this information unless further disclosures 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.

120 W 1470 S Suite 100, St George UT 84770

Financially Responsible Party (FRP) Information Sheet

Name:_____ Date:_____

Client Name:_____

Relationship to Client:_____ Social Security Number _____-_____-_____

Driver License Number:_____ E-mail:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Address:_____

City, State, Zip:_____

Employer Name: _____

Phone Number:_____

Address: _____

Routine Services included in Service Payments: 1. Initial comprehensive substance abuse evaluation, 2. individual meetings with a licensed counselor at least once per week as needed. 3. Group therapy, assignments &/or experiential therapy. 4. On site Family Program if family is available. 5. Urine drug screens may result in additional costs 5. Recovery coaching from a Certified Pier Support Specialist.

Non-Routine Services and Expenses, if needed: These vary significantly between clients, but are often necessary for effective, individualized care. These **expenses are the responsibility of the FRP** and payment must be arranged prior to the particular service. Insurance, if available, may help here. Included is essentially any expense not described in the basic fee (above). Examples: An initial medical screening ($200-300), prescriptions, labs (e.g. urine screens sent out for confirmation, blood data if needed), psychological testing, outside specialist care (e.g. pain specialist, physical therapist, acute medical need).

In the event that any outside costs occur on behalf of this resident during his/her stay at Renaissance Ranch, I give permission for Renaissance Ranch to forward the following credit/debit card information to the provider to pay for such services. Insurance benefits will be used first. Laboratory services will be billed separately from treatment services directly from contracted lab.

Credit Card Authorization

Card: Visa MasterCard American Express Discover

Card #: _____CVC#_____

Name on Card: _____

Expiration Date: _____

Card Billing Address: _____

City, State, Zip: _____

Signature of cardholder: _____

120 W 1470 S Suite 100, St George UT 84770

Department of Finance
Renaissance Ranch St / Las Vegas
St. George, Utah 84770

Communication #0003

BCBS Insurance Payments

If you are receiving this communication your Insurance Company is Blue Cross Blue Shield. When services are rendered to you, we filed a Claim to your Insurance Company which they process in order to issue a payment to your provider Double Decker LLC (Renaissance Recovery). These payments are then sent to the Insurance policy holder, (in your name) and should be brought as soon as you get them to Renaissance Ranch facility, you will know they are for Renaissance Recovery by the EOB that comes together with the check.
If you cash checks that are sent to you but that are meant to pay your provider of services (Renaissance Recovery), you could be facing legal consequences (The legal penalties for check fraud can involve felony charges. Misdemeanor check fraud convictions can result in criminal fines and jail time of up to one year), if this has happened, contact us immediately to help you resolve the situation and avoid further consequences.
To help you accomplish this we will do the following:

- Each time we know a check is on the way, we will call you and text you from our finance department to remind you to bring us the payment sent to you by your Insurance Company.

Important: The checks are to be taken to our facility within no more than 5 working days of delay after you have received them.
Initials: _____ I accept that the mailing address that the Insurance Company has for me be changed to Renaissance Recovery mailing address during the time I am receiving treatment and 60 days after my treatment is over.
By signing I declare that I have read, understood and commit to the guidelines mentioned above.

_____	_____	_____
Signature of Client	**Date**	**Client's Name**

Sincerely,
Renaissance Ranch
Finance Department

*** DO NOT CASH THE CHECK**
*** SIGN OVER TO RENAISSANCE RECOVERY**
*** BRING THE CHECK TO OUR FACILITY**

RENAISSANCE RANCH
ADDICTION TREATMENT CENTERS

SERVICE PAYMENT CONTRACT

Client name:_____

Renaissance Ranch agrees to provide drug/alcohol treatment to the above client in good faith, as outlined below, meeting or exceeding state and industry standards. In return, the Financially Responsible Party (hereafter FRP) agrees to the following:

Routine Services included in Service Payments1. Initial comprehensive substance abuse evaluation, 2. Individual meetings with a licensed counselor at least once per week as needed. 3. Group therapy, assignments &/or experiential therapy. 4. On site Family Program if family is available. 5. Urine drug screens may result in additional costs 5. Recovery coaching from a Certified Pier Support Specialist.
Non-Routine Services and Expenses, if needed: These vary significantly between clients, but are often necessary for effective, individualized care. These **expenses are the responsibility of the FRP** and payment must be arranged prior to the particular service. Insurance, if available, may help here. Included is essentially any expense not described in the basic fee (above). Examples: An initial medical screening ($200-300), prescriptions, labs (e.g. urine screens sent out for confirmation, blood data if needed), psychological testing, outside specialist care (e.g. pain specialist, physical therapist, acute medical need). **GOP:** GOP will be available to clients a minimum of 2 day per week. GOP will be an additional cost and completion is required for lifetime contract.
Insurance: Renaissance Ranch will facilitate billing from Third-Party Payers (e.g. insurance) for our basic services. Renaissance Ranch will bill the maximum allowable and insurance company will determine the payment received. FRP is required to pay deposit up front. If the payments are sent to client's home, client agrees to forward or deliver all payments to Renaissance Ranch.

Payment Schedule	Date Due	Amount	FRP Initials
Tuition Price: Includes $2,500.00 per month for IOP Routine Services	_____	$ 2,500.00	_____
Tuition Price: Includes $1,250.00 per month for GOP Routine Services	_____	$ 1,250.00	_____
Deposit due upon admission:	_____	$_____	_____
Amount due on or before day 30 of treatment.	_____	$_____	_____
Remaining amount due on or before day 60 of treatment.	_____	$_____	_____
Other Payment (if applicable)	_____	$_____	_____
Insurance Deductible Amount	_____	$_____	_____
Total	_____	$_____	_____

Renaissance Ranch cannot declare treatment successfully completed until the discharge balance is paid.

Any unpaid balance is considered delinquent 30 days after the date of discharge. If an account is delinquent FRP agrees to pay any incurred attorney and collection fees of up to 35% of the balance due.

_____I, the FRP, understand and agree to all the above.

_____I, the FRP, understand it is my responsibility to make all insurance premium payments on time, to maintain active and current insurance, to maintain the same insurance policy and plan throughout treatment. If FRP fails to due so, the FRP is responsible for paying $150.00 per day for routine services provided.
_____I, the FRP, also understand and agree that **failure to pay the treatment fees on time could result in the client's discharge from Renaissance Ranch with referral to other programs.**
_____ I the FRP, also understand and agree that given the nature of this service and the level of commitment needed, **the following charges will apply in the event that a client is either voluntary or involuntary discharged from the program: Renaissance Ranch will charge an administrative fee of $300 and the rest of the month will be reimbursed at $150.00 per day.**
_____I the FRP, understand I am responsible for payment of the tuition fee ($150.00 per day for routine services) in the event that my insurance doesn't cover the payment in full.
_____I ***the insured,*** understand that in the event Renaissance Ranch does accept an insurance contract, I hereby authorize insurance claims payment directly to Renaissance Ranch for disbursements otherwise payable to the insured.

Make check or credit payment to: Renaissance Ranch

Financially Responsible Party (Full contact info on client ID form)	**Co-Signer/Client**	Renaissance Ranch **Admissions Staff** I certify this form is complete (2 installment amounts, all names/signatures/dates, copies to FPR and admin file)
_____	_____	_____
x_____ Signature Date	x_____ Signature Date	x_____ Signature Date

Copy to FRP place original in Admin file

rev.2.25.15


RENAISSANCE
RANCH
ADDICTION TREATMENT CENTERS

Recovery Coach Program

Renaissance Ranch Recovery Coaches support positive change by working with our clients to support relapse prevention, build strength, and work on such areas as life goals and relationship building. Recovery Coaching is different from therapy in that they do not address the past, they do not address trauma, and there is little emphasis on feelings. Coaches are non-clinical and do not diagnose or treat mental health and substance abuse issues. The coaches may provide assistance to the clients in accessing such services.

Recovery Coaching is a peer-based program that is developed and provided mainly by those in recovery themselves. As a result, coaches have gained valuable knowledge on how to attain and sustain recovery, and how to access recovery-focused services. Those in or seeking recovery self-direct themselves with the assistance of a coach, much like a life coach. Together, they focus on achieving goals important to the individual. The coach helps to facilitate individual meetings with the client by asking questions and offering suggestions to help the client take the lead in addressing his/her recovery needs.

At Renaissance Ranch our Recovery Coaches work with our clients beyond recovery initiation through stabilization and into recovery maintenance. This type of coaching focuses on principle-based decisions, creating a clear plan of action and using current strengths to reach future goals.

Recovery Coaching Program Expectations

1. Contact Recovery Coach Daily
2. Meet w/ Recovery Coach for a minimum of one hour every week
3. Contact Recovery Coach if feeling any cravings

Client Signature _____ Date _____

FAMILY GROUP AGREEMENT

Requirements:

1. Attend one (1) Addiction Recovery Program(ARP) meeting weekly or attend one (1) Al-anon meeting weekly.
2. Obtain a sponsor/support person who has recovery experience.
3. Report and be anxiously engaged and focused in group on YOUR recovery.
4. Only family members of current Renaissance Recovery clients are invited to attend.

Suggestions:

1. Individual therapy weekly.
2. Daily 12-step meetings.

Agreed and Accepted:

_____ _____

Family Member Name Date

Family Member(s) phone number_____

Family Member(S) email_____

_____

Family Member Signature

_____ _____

Renaissance Ranch Staff Date

_____

Renaissance Ranch Signature

RELEASE OF INFORMATION
Person Requesting and AUTHORIZING the Release of Information:
Requestor Name:
Patient Name:
Address:
Phone:
Email:
Person or Facility which will be DISCLOSING the Requested Information:
Elevated Outcomes, LLC
10542 South Jordan Gateway, Ste. 200
South Jordan Utah 84095
Phone: (801) 266-1280 Fax: (801) 619-8685
Email: pfs@elevatedbilling.com
Person or Facility which will be RECEIVING the Requested Information:
Recipient Name:
Address:
Phone:
Email:
Authorization: By signing this Release of Information, I request and authorize the Disclosing Facility to disclose and share the following personal and/or protected health information with the above Recipient:

- Patient's complete health record (including, but not limited to: all records relating to mental health, medical health, education, evaluations, treatment, financial information, etc.); OR
- Patient's complete record, with the exception of the following information:
- Mental Health Records
- Alcohol/Drug Abuse Treatment
- Other (please specify):

I understand that the information used or disclosed pursuant to this authorization once disclosed to Recipient, may no longer be protected by federal or state law. I also understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. This authorization shall expire automatically 12 months from the date of my signature.
Printed_____
Name Signature_____
Date_____

Limited HIPAA Release
Authorizing Emailed Invoicing
1. Authorization: I authorize Elevated Outcomes, LLC (herein "EO"), an insurance billing and related services provider, contracted with (herein "Treatment Facility"), my behavioral health treatment provider, to use and disclose my Protected Health Information (herein "PHI") as described below.

2. Effective Period: This authorization for release of information shall be limited to the time period during which I or one of my legal dependents received behavioral healthcare services from the above named Treatment Facility and for 12 months thereafter.
3. Limited Extent of Authorization: I specifically authorize EO to email me invoices and other billing related documentation regarding services provided by Treatment Facility at the following email address: I understand that such invoices may contain PHI (i.e. name, address, description of services provided and other necessary health insurance related information).
I understand that I have the right to revoke this authorization, in writing, at any time. I further understand that if I revoke this authorization, my revocation shall not apply where a person or entity has already acted in reliance on my authorization. I further understand that information used or disclosed pursuant to this authorization may, after disclosure, no longer be protected by federal or state law.
Printed Name_____
Signature_____
Date_____

RELEASE OF INFORMATION
Person Requesting and AUTHORIZING the Release of Information:
Requestor Name:_____
Patient Name:_____
Address:_____
Phone:_____
Email:_____
Person or Facility which will be DISCLOSING the Requested Information:
Elevated Outcomes, LLC
10542 South Jordan Gateway, Ste. 200
South Jordan Utah 84095
Phone: (801) 266-1280 Fax: (801) 619-8685
Email: pfs@elevatedbilling.com
Person or Facility which will be RECEIVING the Requested Information:
Recipient Name:_____
Address:_____
Phone:_____
Email:_____
Authorization: By signing this Release of Information, I request and authorize the Disclosing Facility to disclose and share the following personal and/or protected health information with the above Recipient:
- Patient's complete health record (including, but not limited to: all records relating to mental health, medical health, education, evaluations, treatment, financial information, etc.); OR
- Patient's complete record, with the exception of the following information:
- Mental Health Records
- Alcohol/Drug Abuse Treatment
- Other (please specify):

I understand that the information used or disclosed pursuant to this authorization once disclosed to Recipient, may no longer be protected by federal or state law. I also understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. This authorization shall expire automatically 12 months from the date of my signature.

Printed_____

Name Signature_____

Date_____