PARTICIPANT NAME: ____ **Age**: _______

Admissions Team:
Leah Halverson
Steve Kirk
Stephanie Lewis

Please send all paperwork to
Stephanie Lewis
Stephanie@evoketherapy.com
Fax:435.921.0328

OFFICE USE ONLY:

Participant Application to Program Has Been Accepted: ______________________________
Clinical Director Signature

Referral Source: ________________________________ Phone: ____________________

Group #: ________ Therapist: _____________________ Clinical Approval: _____________

Admit Date: ___________ Discharge Date____________ Length of Stay: 35 42 49 56

Arrival Information: ____

Escorted by: ______________________ Approval Conditional? Yes No S _____________

Additional Information/Items Requested

1. Insurance Card (enlarged photocopy, front and back)*

2. Prescription/Pharmacy Card (enlarged photocopy, front and back)*

3. Copies of any recent (last 30 days) medical information, i.e.: x-rays, lab reports, STD, GYN. concerns, etc.

4. Written release and waiver of Tetanus Immunization if a) Participant has not received a Tetanus Immunization in the last ten (10) years and/or b) Participant does not want to receive a Tetanus Immunization (immunization must be within last 10 years. If not, participant will be immunized without release and waiver).

5. Prescription Eyewear (No Contacts allowed in wilderness)

6. Dental Retainer

7. Current Medications (in original pharmacy containers and pharmacy-printed prescription)

8. Record of Immunizations

9. Current IEP if Applicable

* This information is requested to assist with medical insurance claims. Evoke does not bill insurance carriers. However, Evoke will assist with preparation of insurance reimbursement claims after your account has been paid in full. Participant and/ or Financial Guarantor shall be ultimately liable for all medical costs, including the Admission Assessment, regardless of any asserted non-liability by insurers.

In the signature pages to follow,

Please ensure that the participant signs all areas where requested

And the parent or legal guardian/financial guarantor signs all areas requested.

TREATMENT HISTORY AND RELEASE OF INFORMATION

The following professionals and/or institutions who have counseled, treated, or educated ________________________ (participant) are hereby authorized to release all information regarding the medical/treatment history, diagnosis, disability, and/or school records to Evoke, staff and/or consultants who will be involved in participant's program.

EDUCATIONAL CONSULTANT or **REFERRAL SOURCE**: ___________________________

Dates of Consultation/Treatment: ____
Contact Name: ____
Phone: __________________________________ Fax: _____________________________

Name of Therapist, Institution, or Clinic: _______________________________________
Dates of Treatment: ____
Contact Name: ____
Phone: __________________________________ Fax: _____________________________

Name of Therapist, Institution, or Clinic: _______________________________________
Dates of Treatment: ____
Contact Name: ____
Phone: __________________________________ Fax: _____________________________

Participant Signature: ____________________________________ Date: _______________

Parent or Legal Guardian Signature: ___________________________ Date: ____________

PERMISSION TO TEST

I hereby give permission for Evoke at Cascades, directly as well as through third party professionals, to administer and receive reports/results from tests, which are pertinent and appropriate. I/we authorize any professionals who have administered tests to the participant to release information, results and reports to Evoke at Cascades. These may include psychological, academic or medical (see Consent for Examination and Treatment).

Participant Signature: _____________________________________ Date: ______________

Parent or Legal Guardian Signature: ____________________________ Date: ___________

Financial Guarantor Signature: ______________________________ Date: ______________

INSURANCE INFORMATION

Please attach an ENLARGED photocopy, front & back, of the following:

1. **INSURANCE CARD,**
2. **PRESCRIPTION/PHARMACY CARD (if applicable)**
   (this allows Evoke to refill the participant's prescription as needed)

PLEASE NOTE: This information is requested to assist with medical insurance claims. Evoke does not bill insurance carriers. However, Evoke will assist with preparation of insurance reimbursement claims after your account has been paid in full. Participant, Legal Guardian and/or Financial Guarantor shall be ultimately liable for all medical costs, including the Admission Assessment, regardless of any asserted non-liability by insurers.

Name as it appears on Insurance card: ____

Please identify name on card: Father Mother Participant Other: _______________

Participant's Name: __________________________________ Date of Birth: ____________

Policy Number: ____

Group Number: _________________________ RxBIN Number: ______________________

Name of Insurance Company: ____

Insurance Company Address: ____

City: ____________________________________ State: __________ ZIP: _____________

Phone#: __________________________

Insurance: ________________________ Prescription Card: __________________________

Please understand that Evoke will make every effort to have your insurance billed for Participant's prescription; however, some insurance companies do not cover pharmacies in Oregon. If you have any questions, please contact the office.

Participant Signature: _____________________________________ Date: ______________

Parent or Legal Guardian Signature: ___________________________ Date: ____________

Financial Guarantor Signature: _____________________________ Date: ______________

Participant's Physician's name: ____

Address: _______________________________________ Phone: ____________________

Date of Participant's last Medical exam: ____

Participant's Dentist's name: ______________________ Phone: ______________________

EVOKE CONSENT FOR EXAMINATION AND TREATMENT

I/we give permission to Evoke to provide Participant with an Admission Assessment, and to seek medical, hospital, dental, or psychiatric attention in the event of injury or illness, and to provide emergency first aid as needed, in the field until such care can be reached.

I/we understand that all costs of medical care and medication needed while the Participant is enrolled at Evoke Therapy Programs are my/our responsibility.

I/we authorize any professionals who have provided treatment to Participant to release information to Evoke.

I/we are obligated to provide medical insurance for Participant and must provide proof of such prior to the beginning of any program.

I/we understand that Evoke Therapy Programs will control and distribute the Participant's medications as prescribed. I/we further understand upon discharge the Participant's medications remain under the control of Evoke Therapy Programs until Evoke Therapy Programs determines the safest condition of releasing the remaining medications to the Participant or responsible party.

Participant Signature: ______________________________________ Date: __________

Parent or Legal Guardian Signature: ________________________ Date: __________

Financial Guarantor Signature: ________________________________ Date: __________

Name of Medication EXACTLY as indicated on the package	Dosage of each pill (mg, meg, etc.)	Form (tab, liquid)	EXACT number of tablets/units and WHEN they are to be administered					
			AM	NOON	DINNER	BEDTIME	AS NEEDED	OTHER

EVOKE AT CASCADES, INC
POWER OF ATTORNEY

I/we ______________________________________ am/are the Participant or legal guardians of _______________________ (known hereafter as "Participant") and do hereby warrant to the Evoke Therapy Programs , to-wit: Evoke at Entrada, LLC and Evoke at Cascades, Inc (for ease of reference, hereinafter collectively, "Evoke"), which owns and operates the outdoor program commonly known as Evoke Therapy Programs, that I/we have the legal authority to grant this Power of Attorney.

I/we hereby execute this Power of Attorney in order that Evoke may, if necessary, in its judgment, authorize or provide care and treatment to the Participant, as referenced below.

I/we agree to delegate to Evoke while the Participant is in Evoke's custody, any of the powers of the parent or guardian with respect to such Participant regarding his care and custody, including with respect to (a) physical and mental health care and treatment and (b) personal property of the Participant located on his person or located at any Evoke facility or encampment, but in no event shall such power include the power to consent to marriage or adoption of a minor ward. Said power of attorney shall include the power:

- To procure emergency medical, hospital and psychiatric treatment, and to procure dental treatment, should such be deemed necessary for said Participant, as determined by the Evoke representative and/or Evoke's Medical Director.

- To thoroughly search the personal belongings and person of said Participant upon arrival to the program, and during the program if deemed necessary and to confiscate any inappropriate items (considered to be illegal, harmful or unnecessary).

- To physically restrain Participant if Participant is a danger to self or others, as determined by Evoke personnel. Any use of physical force will be documented by the persons involved (insofar as the same is possible), as well as by all witnesses.

- To administer drug screen, pregnancy, and other relevant medical testing.

- To restrain access to telephone calls, visitors, and any deliverable materials as Evoke reasonably deems necessary in connection with Participant's treatment.

I/we execute this Power of Attorney on this_________ day of__________, 20__, effective upon arrival at Evoke on___________ day of _____________, 20___.

This Power of Attorney shall in all events terminate upon said Participant's graduation from the Evoke program in which he is participating or when the parents/legal guardian(s) withdraw said Participant from Evoke. Notwithstanding anything to the contrary herein, I/we shall have the right to revoke said Power of Attorney upon furnishing an executed and written revocation of said Power of Attorney to Evoke. This Power of Attorney shall be construed under Oregon law, without reference to conflict of law principles.

Participant Signature: ____ Date: __________

Parent or Legal Guardian Signature: ________________________________ Date: __________

Participant's Name: _____________________

EVOKE AT CASCADES
CONTRACT FOR SERVICES

PROVIDER:	PARTICIPANT:
Evoke at Cascades, Inc	______________________________
A/K/A Evoke Therapy Programs	______________________________
20332 Empire Avenue, Suite F7	______________________________
Bend, OR 97703	______________________________

This Contract for Services (this "Contract") is made effective as of this _____ day of _________, 20___, by and between the above listed parties and as follows. In this Contract the party who is contracting to receive services, on their own behalf or on behalf of Participant, will be referred to as the 'Client' and/or 'Participant' and/or 'Parents/Legal Guardian' and/or 'Father/Legal Guardian' and/or 'Mother/Legal Guardian' as applicable and as the context may require. The party providing the services, Evoke at Cascades, Inc, an Oregon corporation, will be referred to as "Evoke." The parties may also enter additional agreements, which may govern or otherwise be applicable to this Contract.

1. IDENTIFYING INFORMATION

I/we (the Client and/or Participant and/or the person executing the signature blocks on the last page of this Contract), enter into this contract with Evoke at Cascades for the purpose of securing placement in the Evoke at Cascades Therapy Program ("Evoke Program") and clarifying the rights and responsibilities of the parties.

2. ELIGIBILITY AND ACCEPTANCE

I/we understand that Participant must meet Evoke eligibility requirements for acceptance into the program, and that any misrepresentations relating to eligibility requirements potentially places Participant at great risk and may result in discharge from Evoke. I/we further understand that part of the screening process is completed in the first week of the program, but may take up to three weeks, and agree that Evoke may determine at such time that Participant is clinically or medically inappropriate for placement. If Participant is discharged at such time I/we agree to pay for the return trip home or for travel expenses to another placement. I/we understand that we will be charged only for the days (any time spent at Evoke on any day is counted as a full day) that Participant is enrolled.
_____________ (Participant's initial and date) ______________ (Parent/Financial Guarantor's initial and date)

Participant's Name: _____________________

3. COSTS OF THE EVOKE PROGRAM

I/we understand that the cost of Evoke at Cascades is **$545.00 per day**. I/we further understand that there is a minimum length of stay of **35 days** and that should the decision be made to extend the length of stay for the Participant the extensions will be in seven-day increments billable to a credit card at the rate of **$545.00 per day** as stated above, unless prior arrangements have been made to pay by cash or check. I/we understand that there is an additional **enrollment fee of $2,950.00** due upon admission of the Participant. The enrollment fee covers the application fees and initial gear supplied to the Participant.

Full payment by check, certified check, wire transmission, or credit card for all anticipated costs must be received prior to the beginning of the Evoke Program. Make checks payable to Evoke at Cascades and send via overnight mail to the address in the Payment Agreement. If the decision is made to extend the Participant's stay, or any additional costs are incurred, payment for those costs is due within 10 business days of the decision. Failure to pay may result in the Participant's immediate discharge from the program, and at Client's expense. Such a discharge may be against clinical advice. I/we will not hold Evoke responsible for any consequences that result from the Participant's premature discharge and Client remains liable to pay for any and all costs incurred to that date.

_____________ (Participant's initial and date) ______________ (Parent/Financial Guarantor's initial and date)

4. PREMATURE DISCHARGE

If the Participant is discharged prematurely for medical or clinical reasons, which Evoke retains the right to do, full refund or monies on a per day rate will be given after deduction of expenses incurred by Evoke on behalf of Participant and not included within normal room and board costs. Such expenses would include, but not be limited to, destruction or loss of property by Participant, medical or dental expenses, etc. All gear issued to the Participant remains the property of the Participant, who must assume full responsibility for care and upkeep and replacement cost if the gear is lost or destroyed by the Participant. Any other property, owned by Evoke, Evoke personnel, or any person outside Evoke, which is damaged by the Participant, will be the responsibility of the Participant and the Participant's legal guardians and financial guarantor.

_____________ (Participant's initial and date) ______________ (Parent/Financial Guarantor's initial and date)

If the Participant chooses to leave the program prior to completion (for reasons other than a discharge by Evoke for medical or clinical reasons), participant agrees to be bound by the terms of this Contract for Services for a minimum payment of 21 days (i.e., at the per day rate set forth above). A refund will be made at the established per day rate for days in excess of 21 days, less any out-of-pocket costs incurred by or owed to Evoke with respect to Participant. The foregoing refund policy may be applied more leniently by Evoke but only due to extreme circumstances and in all events subject to Evoke's sole and absolute discretion.

_____________ (Participant's initial and date) ______________ (Parent/Financial Guarantor's initial and date)

5. RUNAWAY EXPENSES

Any costs incurred by the Participant if Participant runs away from Evoke, and expenditures made by Evoke in the pursuit of the Participant will be paid by the Participant and Participant's legal guardian/financial guarantor, who shall be jointly and severally liable for the same. Evoke will make every reasonable effort to find the Participant in as quickly a manner as possible. I/we hereby release, hold harmless and indemnify Evoke from any and all liability arising out of or resulting from the Participant running away while enrolled, except for any liability arising out of Evoke's gross negligence.

_____________ (Participant's initial and date) ______________ (Parent/Financial Guarantor's initial and date)

Participant's Name: ____________________

6. TRAVEL TO AND FROM THE EVOKE PROGRAM

I/we agree to pay in full for and make arrangements for the Participant to travel to and from Evoke, including all mid-program travel to and from the program. I/we agree that any such arrangements will be made by Participant with professional transport agencies and that Evoke will have no responsibility or liability for any travel or any events which may occur during delivery to Evoke.

_____________ (Participant's initial and date) ______________ (Parent/Financial Guarantor's initial and date)

7. RISKS OF THE OUTDOOR PROGRAM

A. Illness/Injury/Medical Condition. I/we assume and acknowledge that living in the outdoors brings the possibility of injury or illness in the normal course of events. I/we agree to release, hold harmless and indemnify Evoke and its owners, employees and agents from any and all liability arising out of or resulting from any injury or illness which occurs while the Participant is enrolled, except to the extent attributable to Evoke's gross negligence. Additionally, I/we hereby release, hold harmless and indemnify Evoke, its owners, employees and agents from any and all liability arising out of or resulting from any medical condition which is self-inflicted by the Participant while enrolled, including without limitation any self-inflicted injury or illness.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

B. Indemnification. I/we and any and all of our agents, officers, directors, shareholders, members, employees, heirs, representatives, successors, predecessors, related entities, and assigns agree to release from liability and shall indemnify and hold Evoke and any and all of its agents, officers, directors, shareholders, members, employees, heirs, representatives, successors, predecessors, related entities, or assigns, harmless from damages or obligations incurred by me/us under this Contract or from any and all claims, losses, liabilities, demands, actions, suits, expenses, attorney fees, rents, and compensation of any kind and nature whatsoever, whether present or future, known or unknown, anticipated or unanticipated, which I/we ever had or now have in any way arising out of or in any way relating to this Contract or the services provided hereunder, except for any liability arising from Evoke's gross negligence.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

8. POWER OF ATTORNEY

By signing the Power of Attorney in the enrollment application, and without limiting the Power of Attorney in any manner, I/we agree to delegate to Evoke, for the duration of the Participant's enrollment with Evoke, any of the powers inherent in such power of attorney.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

9. CONFIDENTIALITY AND USE OF PARTICIPANT'S RECORDS AND PICTURES

A. Evoke collects health and mental health data throughout the treatment process in order to provide a safe and effective treatment environment. Evoke seeks to maintain the confidentiality of all data and records associated with this research including the transmission, storing, and reporting of information. I agree to allow Evoke to gather and use data collected during the course of treatment for program development and research purposes. Those purposes may include professional publications on research, presentations, and training.

__________ (Participant's initial and date) _____________ (Parent or Legal Guardian's initial and date)

B. During the course of Participant's involvement in the Evoke program, other parents, Educational Consultants, Referring Professionals, or other guests invited by Evoke whom Evoke reasonably believes have a valid interest in Evoke programs either by virtue of their relationship to the Participant or Evoke, may visit the field during Participant's stay. By signing below, Participant and/or, if applicable, the legal guardian agree that the Participant's participation in the Program will constitute the consent of the Participant or the legal guardians to such interactions.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

Participant's Name: ____________________

C. During the course of Participant's involvement in the Evoke program, such Participant may take pictures of other Participants with his or her own disposable camera. Further, when family members or other invited guests of such Participant visit the field during or at the conclusion of such Participant's stay, it is possible that pictures of the Participant may be taken by such persons. By signing below, I/we agree that participation in an Evoke Therapy Program will constitute the consent of both the Participant and/or, if applicable, the legal guardian to such pictures being taken, as well as constitute a waiver of any claims against Evoke arising out of the taking or use of such pictures.
_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

10. AUTHORIZATION AND CONSENT FOR COMMUNICATIONS

A. I/we authorize Evoke to transmit personal communications from the Participant by posting on a secure (password-protected) webpage, to be arranged after the Participant's arrival at Evoke. I/we understand that errors may occur in the transmission of personal communications and that while postings are made on password-protected webpage, Evoke cannot absolutely guarantee security of the webpage under all circumstances. I/we hereby release Evoke from any and all liability for errors in the transmission of personal communications, except for any liability arising out of Evoke's gross negligence. I/we agree to keep confidential the nature of any communication that I/we may receive in error and to notify the Evoke Program immediately.
_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

B. I/we give Evoke permission to enroll and provide curriculum materials to Participant for the purpose of obtaining high school educational credits when necessary. ___________________(Participant's initial and date) ___________________(Parent or Legal Guardian's initial and date)

C. I/we agree that all relevant information concerning Participant may be delivered to third parties as reasonably deemed appropriate to Evoke to deal with the following situations:

a. If Participant is a danger to self;
b. If Participant is a danger to someone else;
c. If Participant shares information of physical or sexual abuse, applicable law requires disclosure to appropriate persons or the Participant is or otherwise may be at risk.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

11. AUTHORIZATION AND CONSENT FOR COMMUNICATIONS RELEASE

A. I/we give consent for Evoke therapists, management, and staff to communicate (and/or exchange) all information concerning Participant's medical and clinical treatment, diagnosis, disability, school and legal records, or any other information regarding Participant, with parties who are directly involved with Participant's therapeutic process, i.e., parents, spouse, sponsor (if any), Financial Guarantor (if any), Educational Consultant/Referring Professional, home therapist.
_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

B. I/we hereby grant permission for Evoke to provide contact information to an assigned Parent Mentor, namely a parent of an Evoke alumni participant who will therefore not likely be an employee of Evoke. I/we authorize said mentor to contact Participant's parents, legal guardian, Financial Guarantor, and/or sponsor during my stay at Evoke for the purpose of outreach and support.
_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

Participant's Name: _____________________

C. I/we hereby grant permission for Participant's assigned therapist and/or my Education Consultant/Referring Professional ____________________________________ (name) to read mail and see photos posted to the secure webpage. I/we understand and give permission for Participant's group photos to be posted for all families in the Participant's group. These images remain password-protected from all others.
_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

D. Please complete and sign this section listing Educational Consultants, Referring Professionals, parents and/or other family members, psychologists, confidants, etc. who we may be in contact with regarding Participant's treatment and with whom we may exchange such information concerning Participant as we deem appropriate in our reasonable discretion. The following listing shall not be exclusive, it being understood that Evoke may have contact with other persons as provided in Sections A. through C. above, according to the terms of Sections A. through C., even if they are not listed below:

NAME	ADDRESS	PHONE#	FAX#	EMAIL

I/we understand that signing the Communication Consent to Release section is not required for acceptance of my application to Evoke.

Participant's Signature: ____ Date: _______________

Parent or Legal Guardian's Signature: ________________________________ Date: _______________

12. WITHDRAWAL OF PARTICIPANT

In the event the Participant or Participant's legal guardian demands the withdrawal of the Participant from Evoke custody, and upon reasonable proof and Evoke's determination that such person, acting alone, has the lawful authority to make such a demand, Evoke will release the Participant to such requesting person. The Participant and/or legal guardian and/or Financial Guarantor (if any) agree to indemnify and hold Evoke harmless from and against any and all claims (including legal fees) arising from such release and from and against any and all legal fees and costs incurred by Evoke in consulting legal counsel as to its rights and obligations with respect to a withdrawal under circumstances in which all legal guardians do not provide written consent to withdrawal of the Participant. If there is more than one legal guardian, and all such legal guardians sign this Contract for Services, they agree, without limiting Evoke's other rights herein, that Evoke shall have the right to condition withdrawal only upon all such legal guardians giving such written consent. If Evoke should otherwise conclude that the consent of all legal guardians for such a withdrawal is not necessary, Evoke will undertake reasonable efforts to attempt to notify the non-requesting legal guardian of the release if such non-requesting legal guardian has executed this Contract for Services or Evoke is otherwise legally required to give such notification.
_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

13. ENTIRE AGREEMENT

This Contract, if executed, contains the entire agreement of the parties with respect to the subject matter of this Contract. This Contract supersedes any prior written or oral agreements between the parties. Any modifications to this Contract of any kind must be in writing and signed by the party obligated under the modification.
_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

Participant's Name: ____________________

14. GOVERNING LAW

This Contract shall be construed in all respects in accordance with the laws of the State of Oregon, without regard to conflicts of laws principles that would require the application of any other law.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

15. JURISDICTION

Client irrevocably agrees and hereby consents to submit to the jurisdiction of any state or federal court (assuming federal jurisdiction exists) residing in the State of Oregon. Should jurisdiction exist in the State Courts of Oregon, venue shall reside in the Deschutes County Circuit Court of Oregon. Client hereby waives any right Client may have to transfer or change the venue of any litigation filed in such courts.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

16. SEVERABILITY

If any provision of this Contract will be held to be invalid or unenforceable for any reason, the remaining provisions will continue to be valid and enforceable. If a court finds that any provision of this Contract is invalid or unenforceable, but that by limiting such provision it would be valid and enforceable, then such provision will be deemed to be written, construed, and enforced as so limited.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

17. ATTORNEY FEES

In the event a suit is brought by any party under this Contract to enforce any of its terms, conditions or covenants, or in any appeal therefrom, it is agreed that the prevailing party shall be entitled to recover its attorney fees, experts' fees, and/or costs incurred in any action.

_____________ (Participant's initial and date) ______________ (Parent/Financial Guarantor's initial and date)

18. COLLECTION COSTS

In the event any amounts due to Evoke under this agreement are not paid within the time periods specified in the Evoke Payment Agreement (the "Payment Agreement") executed simultaneously herewith, I/we agree to pay finance charges of 12% APR as more particularly outlined in the Payment Agreement.

_____________ (Participant's initial and date) ______________ (Parent/Financial Guarantor's initial and date)

19. NOTICE

Any notice or communication required or permitted under this Contract shall be sufficiently given if delivered in person or by certified mail, return receipt requested, to the address set forth on the front page of this contract or to such other address as one party may have furnished to the other in writing.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

20. FAMILY INVOLVEMENT

I/we understand that Evoke expects parents/families/spouses/sponsors to be enrolled and participating in Family Therapy.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

In the event that consultation between Evoke and the parents/family/spouses/sponsors therapist is relevant to the treatment of the Participant, please provide the Therapist contact information.

Family Therapist: ________________________________ Phone #: _____________________________________

Participant's Name: __________________

21. HEALTH INSURANCE REIMBURSEMENT

I/we understand I/we will be billed at the rate as stated in Section 3 hereof. I/we also agree to make all payments as outlined in this Contract. Evoke does not guarantee that it or its third party insurance processors will be successful in their insurance reimbursement efforts. I/we understand that Evoke will pay the initial $250 registration fee. I/we understand that any other fees are my/our responsibility. Denials Management, INC. is an independent contractor that will render the services referenced in the attached letter in an attempt to help patient secure health insurance reimbursement for the amount it is paying to Evoke hereunder.

__________(Participant's initial and date) ______________(Parent or Legal Guardian's initial and date)

22. PARTICIPATION COMMITMENT

I/we understand that the program is a demanding physical and emotional experience and agree that the Participant will participate in and accept stressful physical and mental challenges as being part of the treatment experience. The Participant agrees to participate in all clinical and wilderness activities. Participant acknowledges that completion of the program does not necessarily mean that Participant has successfully completed all necessary therapy.

_____________ (Participant's initial and date) ________________ (Parent or Legal Guardian's initial and date)

ACCEPTED AND AGREED:

I/we accept the terms and conditions of this Agreement and declare that all of the information in the Application Packet is true and correct.

Participant Signature: ____ Date: ____________

Home Address: _______________________________________ Driver License Number: __________________

Parent or Legal Guardian Signature:*____ Date: ________

Financial Guarantor Signature:*_______________________________________ Date: ________

***The signature of legal guardian and/or financial guarantor shall also indicate, unless otherwise agreed upon in writing by Evoke, that legal guardian and financial guarantor are jointly and severally liable (along with Participant) for the prompt payment when due of all liabilities and obligations hereunder, including, but not necessarily limited to program enrollment and daily fees, runaway expenses, travel expenses, medical and dental expenses, costs of collections and indemnity obligations.**

<u>Evoke at Cascades Payment Agreement</u>

1. TUITION INFORMATION

You (meaning you, the Participant and/or legal guardian and/or Financial Guarantor, if any) acknowledge that daily tuition fees apply to EVERY full or partial day that Participant is enrolled in a program (each such program an "Evoke Therapy Program") operated by Evoke at Cascades, Inc ("Evoke). The cost is **$545.00 per day**, **plus a $2,950.00 enrollment fee.** There is a **<u>minimum</u>** initial payment of **$22,025.00** which covers the first **35 days** of the program and includes the enrollment fee. The initial payment is due **on or before** the participant's date of enrollment. If payment is not received within **7** days of enrollment, you authorize Evoke to charge the credit card (the "Credit Card") you provide to Evoke when you completed your online application. ***<u>All late payments will accrue finance charges at a rate of 12% APR beginning 8 days after the first billing date. All extensions beyond your initial payment will be billed to the Credit Card at a rate of $545.00 per day, unless prior arrangements have been made with the Accounting Department to pay by check or wire transfer. Credit Card charges will be reversed if payment by check or wire transfer is subsequently received.</u>***

2. PREFERRED METHOD OF PAYMENT - circle length of stay

35 days = $22,025.00 **42 days = $25,840.00** **49 days = $29,655.00** **56 days = $33,470.00**

☐ **Check Payable to Evoke at Cascades**

Please send payment to: Evoke at Cascades, 20332 Empire Ave., Suite F7, Bend, OR 97703
Ph: 541-382-1620 (Include UPS/FEDEX tracking number here ______________________________________)

☐ **Wire Transfer** (Please contact the billing department at 541-382-1620 for wiring instructions)

☐ **Credit Card -** You authorize and request Evoke to charge all tuition and enrollment fees to the Credit Card. (Unless otherwise noted, the credit card supplied in the online application will be the credit card that is charged.)

3. TRANSPORTATION, MEDICAL, AND INCIDENTAL EXPENSES

Regardless of your selected payment method of tuition and enrollment fees, and unless you have made other payment arrangements that are approved in advance by Evoke, **you authorize Evoke to charge the following to the Credit Card:** (i) All expenses not covered by tuition or enrollment fees that are incurred by Evoke on behalf of Participant; (ii) all additional tuition incurred by reason of extensions to Participant's stay in the Evoke Therapy Program; (iii) all travel and transportation expenses related to a temporary leave, and a discharge beyond the Participant being brought to Evoke's field office (ranging from $500-$1500 which does not include airfare, contact the program at the number above for specific amounts); (iv) ALL MEDICAL EXPENSES incurred by Evoke while Participant is in the Evoke Therapy Program, including the Admission Assessment. Evoke does not bill insurance carriers. Evoke will assist with preparation of insurance reimbursement claims only after your account has been paid in full. You agree that so long as Participant remains enrolled in any Evoke Therapy Program, you will promptly notify Evoke of any changes to your Credit Card account number, expiration date and/or your billing address, and you agree to promptly notify Evoke if your Credit Card expires or is cancelled for any reason. You agree to indemnify, defend and hold harmless Evoke from and against any and all claims, expenses, charges, damages, and fees incurred by Evoke as a result of or relating to your failing to provide correct and/or current information regarding the Credit Card to Evoke.

Participant: ________________________________ **Signature** ______________________________ **Date:** ________
(Please print)

Financial Guarantor: ________________________ **Signature** ______________________________ **Date:** ________
(Please print)

Parent or Legal Guardian: _________________________ **Signature** ________________________ **Date:** ________
(Please print)

NATSAP Adult Student/Client Consent Form University of New Hampshire

TITLE OF RESEARCH STUDY

You are invited to participate in a research study called the NATSAP Research and Evaluation Network. NATSAP stands for: National Association of Therapeutic Schools and Programs (www.natsap.org). The program you are enrolled at is a member of this organization.

WHAT IS THE PURPOSE OF THIS STUDY?

This study is designed to measure if your program helps you. The study should be able help the program to improve its services.

WHAT DOES YOUR PARTICIPATION IN THIS STUDY INVOLVE?

You will be asked to fill out 2 -3 questionnaires about your behavior such as how well you have been getting along with others and how you have been feeling about yourself.

You will be asked to complete questionnaires at 3 different times:

1) When you start the program 2) When you leave the program 3) One year after you leave the program

You can fill these forms out on a computer at a website that has been set up for the study. You will get e-mail reminders and instructions that will help you to do this. Paper forms can be used instead.

Your parent(s)/Guardian(s) are also being asked to fill out questionnaires.

WHAT ARE THE POSSIBLE RISKS OF PARTICIPATING IN THIS STUDY?

There are no physical risks. You may feel uncomfortable when you share personal information about yourself or your family. You should feel free to talk about any discomfort you feel with staff from your program. You may quit the study at any time.

WHAT ARE THE POSSIBLE BENEFITS OF PARTICIPATING IN THIS

STUDY?

This study is designed to help your program get better at helping students and clients. Your participation could help other children who will attend the program in the future.

It is possible that the program will use the information from the questionnaires you fill out to help them create a treatment plan

If you choose not to participate you will still have access to every other aspect of the program and treatment that you would have otherwise.

IF YOU CHOOSE TO PARTICIPATE IN THIS STUDY, WILL IT COST YOU ANYTHING?

There is no cost

WHAT OTHER OPTIONS ARE AVAILABLE IF YOU DO NOT WANT TO TAKE PART IN THIS STUDY?

You understand that your consent to participate in this research is entirely voluntary, and that your refusal to participate will involve no loss of benefits that you would otherwise have received.

CAN YOU WITHDRAW FROM THIS STUDY?

If you consent/agree to participate in this study, you are free to stop your participation in the study at any time without loss of benefits to which you would otherwise be entitled

HOW WILL THE CONFIDENTIALITY OF YOUR RECORDS BE PROTECTED?

The University of New Hampshire and your program seek to maintain the confidentiality of all data and records associated with your participation in this research.

You should understand, however, there are rare instances when the researcher is required to share personally-identifiable information (e.g., according to policy, contract, regulation). For example, in response to a complaint about the research, officials at the University of New Hampshire, designees of the sponsor(s), and/or regulatory and oversight government agencies may access research data.

You also should understand that the researcher is required by law to report certain information to government and/or law enforcement officials (e.g., child abuse, threatened violence against self or others, communicable diseases).

All the forms that are filled out at the study website will be stored securely and accessible by approved program staff and the University of New Hampshire research

coordinators through password access only. When the information is made available to other researchers, it will be stripped of anything that would identify it as yours.

If paper forms are used, they will be locked securely at your program after they have been entered into the computer system described above.

WHOM TO CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY

If you have questions about your rights as a research subject you can contact Julie Simpson in the UNH Office of Sponsored Research, 603-862-2003 or Julie.simpson@unh.edu to discuss them.

If you have read these statements, understand them, and consent to participate, please sign and date this document in the field provided below.

____
_____________________ Student/Client Signature Date