



STUDENT 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:

Referral Source: _____ Phone: _____

Group #: _____ Therapist: _____ Clinical Approval: _____

Admit Date: _____ Discharge Date: _____ Length of Stay: 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) student/child has not received a Tetanus Immunization in the last ten (10) years and/or b) you do not want your student/child to receive a Tetanus Immunization (immunization must be within last 10 years. If not, student/child will be immunized without release and waiver). Tetanus Immunization dates/records must be provided. In the absence of dates/records, student/child will be immunized upon enrollment.
5. Prescription Eyewear (No Contacts allowed in wilderness)
6. Dental Retainer
7. Current Medications (in original pharmacy containers and pharmacy-printed prescription). Note: Evoke will obtain refills of all medications locally using the doctor who conducts the student/child's intake physical, unless otherwise noted or requested.
8. Record of Immunizations
9. Current IEP

*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. Parents/legal guardians shall be ultimately liable for all medical costs associated with your student/child, including the Admission Assessment, regardless of any asserted non-liability by insurers.

*****If Parents are NOT married*****

**Both parents must sign all "signature pages" or
provide a copy of Court Ordered Custody Papers declaring
LEGAL and PHYSICAL Custody**

TREATMENT HISTORY AND RELEASE OF INFORMATION

The following professionals and/or institutions who have counseled, treated, or educated _____ (student/child) 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 our son/daughter'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: _____

Parent/ Legal Guardian Signature: _____ Date: _____

Parent/ Legal Guardian Signature: _____ Date: _____

PERMISSION TO TEST

I hereby give permission for Evoke at Entrada, 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 my student/child to release information, results and reports to Evoke at Entrada. These may include psychological, academic or medical (see Consent for Examination and Treatment).

Parent/ Legal Guardian Signature: _____ Date: _____

Parent/ 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 your student/child'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. Parents/legal guardians and financial guarantor (if applicable) shall be ultimately liable for all medical costs associated with your student/child, 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 Student Other: _____

Student/Child 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 your student/child's prescription; however, some insurance companies do not cover pharmacies in Utah. If you have any questions, please contact the office.

Parent/ Legal Guardian Signature: _____ Date: _____

Financial Guarantor Signature: _____ Date: _____

Student/Child's Physician's name: _____

Address: _____ Phone: _____

Date of Student/Child's last Medical exam: _____

Student/Child's Dentist's name: _____ Phone: _____

EVOKE CONSENT FOR EXAMINATION AND TREATMENT

I/we give permission to Evoke Therapy Programs to provide student/child 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 student/child is enrolled at Evoke Therapy Programs are my/our responsibility.

I/we authorize any professionals who have provided treatment to student/child to release information pertaining to student/child to Evoke Therapy Programs.

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

I/we understand that Evoke Therapy Programs will control and distribute the Student's medications as prescribed. Evoke Therapy Programs will obtain refills of all medications locally using the doctor who conducts the student/child's Admission Assessment, unless otherwise noted or requested. I/we further understand upon discharge the Student'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 parent/legal guardian or responsible party.

Parent/ 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 ENTRADA
POWER OF ATTORNEY**

I/we _____ are the parents and/or legal guardians of _____ (known hereafter as “Student”) 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 Program, that I/we have the legal authority to grant this Power of Attorney.

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 Student, as referenced below.

I/we agree to delegate to Evoke while the Student is in Evoke’s custody, any of the powers of the parent or guardian with respect to such Student regarding Student’s care and custody, including with respect to (a) physical and mental health care and treatment and (b) personal property of the Student located on Student’s 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 Student, as determined by the Evoke representative and/or its Medical Director.
- To thoroughly search the personal belongings and person of said Student 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 Student if the Student is a danger to self or others, as determined by Evoke personnel. Any use of physical force will be documented by all adult witnesses present.
- Should Student run away from control and supervision of Evoke staff, to direct and authorize appropriate law enforcement or security personnel to detain and retain custody of the Student until arrangement is made for Student’s immediate return to Evoke, home or next placement.

We give permission for said Student to participate in all program activities, knowing that such activities carry an inherent risk of injury or illness.

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 Student’s graduation from the Evoke program in which Student is participating or when the parents/legal guardian(s) withdraw said Student 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 Utah law, without reference to conflict of law principles.

Father/Legal Guardian Signature

Mother/Legal Guardian Signature

Student Name: _____

ENTRADA AT EVOKE CONTRACT FOR SERVICES

PROVIDER:

Evoke at Entrada, LLC
A/K/A Evoke Therapy Programs
2711 Santa Clara Drive Suite 400
Santa Clara, Utah 84765

CLIENT (Parents/Legal Guardian):

This Contract for Services (this "Contract") is made effective as of this ____ day of _____, 20____, by and between the above listed parties. In this contract, the party who is contracting to receive services will be referred to as the "Client" and/or "Parents/Legal Guardian" and/or "Father/Legal Guardian" and/or "Mother/Legal Guardian". The party providing the services, Evoke at Entrada, LLC, a Nevada limited liability company, 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, (Parents or guardians) _____ the parents/legal guardians of _____ (the "Student's" name), enter into this contract with Evoke for the purpose of securing placement of the Student in the Evoke at Entrada Therapy Program ("Evoke Program") and clarifying the rights and responsibilities of each party. **If one parent signs the contract, such parent is representing and warranting that both parents are consenting to the Student's admission. In the case of divorce or unmarried guardians, I/we state that we are in fact the legal guardians of the Student, and have the authority to act and make decisions regarding the Student, alone, and will provide documentation showing such authority before the Student begins the program** _____ (initial and date)

2. ELIGIBILITY AND ACCEPTANCE

I/we understand that the Student must meet Evoke's eligibility requirements for acceptance into the Evoke Program, and that our misrepresentation of any facts regarding the Student's eligibility for the Evoke Program potentially places the Student 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 Evoke Program, and sometimes it may take as long as three to four weeks for Evoke to determine the Student is not appropriate for the program. I/we acknowledge that Evoke may determine during such period of time that the Student is clinically or medically inappropriate for placement. If as a consequence the Student is discharged at this 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 the Student is enrolled. _____ (initial and date)

3. COSTS OF PROGRAM

I/we understand that the cost of Evoke at Entrada is **\$525.00 per day**. I/we further understand that there is a minimum length of stay of **42 days** and that should the decision be made to extend the length of stay for my child the extensions will be in seven-day increments billable to a credit card, at the rate of **\$525.00 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 Student. The enrollment fee covers the application fees and initial gear supplied to the Student. _____ (initial and date)

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 and send via overnight mail to the address in the Payment Agreement. If the decision is made to extend the Student'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 Student'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 Student's premature discharge and Client remains liable to pay for any and all costs incurred to that date. _____ (initial and date)

Student Name: _____

4. PREMATURE DISCHARGE

If the Student 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 Student and not included within normal room and board costs. Such expenses would include, but not be limited to, destruction or loss of property by Student, costs incurred in attempting to locate Student if Student runs away from the program, medical or dental expenses, etc. All gear issued to and paid for by the Student remains the property of the Student, Student must also assume full responsibility for replacement cost of new gear if the gear previously issued to and paid for by (or loaned to) Student is lost or destroyed. Any other property, owned by Evoke, Evoke personnel, or any person outside Evoke, which is damaged by the Student, will be the responsibility of the Student and the Student's parents, legal guardians and financial guarantor. _____ (initial and date)

If the Student leaves the program prior to completion (for reasons other than a discharge by Evoke for medical or clinical reasons), parents/legal guardians/financial guarantor agree 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 Student. 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. _____ (initial and date)

5. RUNAWAY EXPENSES

Any costs incurred by the Student if Student runs away from Evoke, and expenditures made by Evoke in the pursuit of the Student will be paid by the Student's parents/legal guardians and financial guarantor, if any. Evoke will make every reasonable effort to find the Student 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 Student running away while enrolled, except for any liability arising out of Evoke's gross negligence. _____ (initial and date)

6. TRAVEL TO AND FROM THE EVOKE PROGRAM

I/we agree to pay in full for and make arrangements for the Student 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 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. _____ (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 Student 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 Student while enrolled, including without limitation any self-inflicted injury or illness. _____ (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. _____ (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 Student's enrollment with Evoke, any of the powers of the parent or guardian regarding care, custody or property of the Student, except the power to consent to marriage or adoption of a minor ward. _____ (initial and date)

Student Name: _____

9. CONFIDENTIALITY AND USE OF STUDENT'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 from myself and my child collected during the course of treatment for program development and research purposes. Those purposes may include professional publications on research, presentations, and training. _____ (initial and date)

B. During the course of Student'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 Student or Evoke, may visit the field during Student's stay. By signing below, parents/legal guardians agree that the Student's participation in the Program will constitute the consent of the Student and/or the parents/legal guardians to such interactions. _____(initial and date).

C. During the course of Student's involvement in the Evoke program, such Student may take pictures of other Students with Student's own disposable camera. Further, when family members or other invited guests of such Student visit the field during or at the conclusion of such Student's stay, it is possible that pictures of the Student may be taken by such persons. By signing below, parents/guardians agree that participation in an Evoke Therapy Program will constitute the consent of both the Student and/or the parents/legal guardians 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. _____ (initial and date)

10. AUTHORIZATION AND CONSENT FOR COMMUNICATIONS

A. I/we authorize Evoke to transmit personal communications from the Student to me by posting on a secure (password-protected) webpage, to be arranged after the Student'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. _____ (initial and date)

B. I/we give Evoke permission to enroll Student and provide curriculum materials to Student for the purpose of obtaining high school educational credits
_____ (initial and date)

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

- a. If Student is a danger to self;
- b. If Student is a danger to someone else;
- c. If Student shares information of physical or sexual abuse, and applicable law permits or requires disclosure to appropriate persons. _____ (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 Student's medical and clinical treatment, diagnosis, disability, school and legal records, or any other information regarding Student, with parties who are directly involved with Student's therapeutic process, i.e., parents, spouse, Educational Consultant/Referring Professional, home therapist. _____ (initial and date)

B. I/we hereby grant permission for Evoke to provide my contact information to an assigned Parent Mentor, namely a parent of an Evoke alumni student who will therefore not likely be an employee of Evoke. I/we agree to be contacted by said Parent Mentor during my Student's stay at Evoke for the purpose of outreach and support.
_____ (initial and date)

C. I/we hereby grant permission for Student's assigned therapist _____ (initial and date) and/or Student's Education Consultant/Referring professional _____ (name) _____ (initial and date) to read mail and see photos posted to the secure webpage. I/we understand and give permission for Student's group photos to be posted for all families in the Student's group. These images remain password-protected from all others.
_____ (initial and date)

Student Name: _____

D. Please complete and sign this section listing Education Consultants, Referring Professionals, parents and/or other family members, psychologists, confidants, etc. who we may be in contact with regarding Student’s treatment and with whom we may exchange such information concerning Student 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 Section A. through C. above, according to the terms of Section 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.

Parent/Legal Guardian’s Signature: _____ Date: _____

12. WITHDRAWAL OF STUDENT

In the event either parent or legal guardian demands the withdrawal of the Student 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 Student to such requesting person. The parent/legal guardian/financial guarantor agree to indemnify and hold Evoke harmless from and against any and all claims 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 both parents do not provide written consent to withdrawal of the student. If both parents 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 both parents giving such written consent. If Evoke should otherwise conclude that the consent of both parents for such a withdrawal is not necessary, Evoke will undertake reasonable efforts to attempt to notify the non-requesting parent of the release if such non-requesting parent has executed this Contract for Services or Evoke is otherwise legally required to give such notification. _____ (initial and date)

13. ENTIRE AGREEMENT

This Contract 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. _____ (initial and date)

14. GOVERNING LAW

This Contract, if executed, shall be construed in all respects in accordance with the laws of the State of Utah, without regard to conflicts of laws principles that would require the application of any other law. _____ (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 Utah. Should jurisdiction exist in the State Courts of Utah, venue shall reside in the Fifth Judicial District Court of Utah. Client hereby waives any right Client may have to transfer or change the venue of any litigation filed in such courts. _____ (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. _____ (initial and date)

Student Name: _____

17. ATTORNEY FEES

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

20. FAMILY INVOLVEMENT

I/we understand that Evoke expects parents/families to be enrolled and participating in Family Therapy. _____ (initial and date) In the event that consultation between Evoke and the family therapist is relevant to the treatment of the Student, please provide your Family Therapist contact information.

Family Therapist: _____ Phone #: _____

21. HEALTH INSURANCE REIMBURSEMENT

I/ 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. _____ (initial and date)

ACCEPTED AND AGREED:

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

Father/Legal Guardian*: _____ Date: _____

Mother/Legal Guardian*: _____ Date: _____

Financial Guarantor (if applicable)*: _____ Date: _____

*The signature of father, mother, legal guardian and/or financial guarantor shall also indicate, unless otherwise agreed upon in writing by Evoke, that such persons are jointly and severally liable 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.

Evoke at Entrada Payment Agreement

1. TUITION INFORMATION

You (meaning Parent/Guardian and Financial Guarantor, if any) acknowledge that daily tuition fees apply to EVERY full and partial day that your student/child is enrolled in a program (each such program an "Evoke Therapy Program") operated by Evoke at Entrada, LLC ("Evoke"). The cost is **\$525.00 per day, plus a \$2,950.00 enrollment fee**. There is a **minimum** initial payment of **\$25,000.00** which covers the first **42 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 the online application. **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 \$525.00 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.

2. PREFERRED METHOD OF PAYMENT - circle length of stay

42 days = \$25,000.00

49 days = \$28,675.00

56 days = \$32,350.00

Check Payable to Evoke at Entrada

Please send payment to: Evoke at Entrada, 2711 Santa Clara Drive, Santa Clara, UT 84765
Ph: 435-674-9310 (Include UPS/FEDEX tracking number here _____)

Wire Transfer (Please contact the billing department at 435-674-9310 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 your student/child; (ii) all additional tuition incurred by reason of extensions to your student/child's stay in the Evoke Therapy Program; (iii) all travel and transportation expenses related to a temporary leave, and a discharge beyond the student 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 your student/child is in the Evoke Therapy Program. 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 your student/child 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.

Parent: _____ **Signature** _____ **Date:** _____
(Please print)

Financial Guarantor: _____ **Signature** _____ **Date:** _____
(Please print)

ICPC PART 1, PLEASE COMPLETE THE AREAS BELOW

ICPC 100A
REV. 8/2001

**One form per child
Please type**

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

TO:

FROM:

Please complete this section

SECTION I - IDENTIFYING DATA

Notice is given of intent to place - Name of Child:			Ethnicity: Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to determine/unknown	
Social Security Number:		ICWA Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White	
Sex:	Date of Birth	Title IV-E determination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		
Name of Mother:			Name of Father:	
Name of Agency or Person Responsible for Planning for Child:				Phone:
Address:				
Name of Agency or Person Financially Responsible for Child:				Phone:
Address:				

Fill in Sect. 1

SECTION II - PLACEMENT INFORMATION

Name of Person(s) or Facility Child is to be placed with: Evoke at Entrada		Soc Sec # (optional): Soc Sec # (optional):	
Address: 2711 Santa Clara Dr. Santa Clara, UT 84765		Phone: 435-674-9310	
Type of Care Requested: <input type="checkbox"/> Foster Family Home <input type="checkbox"/> Group Home Care <input type="checkbox"/> Child Caring Institution		<input type="checkbox"/> Parent <input type="checkbox"/> Relative (Not Parent) Relationship: _____ <input checked="" type="checkbox"/> Other: Outdoor Youth Treatment	
<input type="checkbox"/> Residential Treatment Center <input type="checkbox"/> Institutional Care-Article VI, Adjudicated Delinquent		<input type="checkbox"/> ADOPTION <input type="checkbox"/> IV-E Subsidy <input type="checkbox"/> Non IV-E Subsidy To Be Finalized In: <input type="checkbox"/> Sending State <input type="checkbox"/> Receiving State	
Current Legal Status of Child: <input type="checkbox"/> Sending Agency Custody/Guardianship <input checked="" type="checkbox"/> Parent Relative Custody/Guardianship <input type="checkbox"/> Court Jurisdiction Only		<input type="checkbox"/> Protective Supervision <input type="checkbox"/> Parental Rights Terminated-Right to Place for Adoption <input type="checkbox"/> Unaccompanied Refugee Minor <input type="checkbox"/> Other:	

SECTION III - SERVICES REQUESTED

Initial Report Requested (if applicable): <input type="checkbox"/> Parent Home Study <input type="checkbox"/> Relative Home Study <input type="checkbox"/> Adoptive Home Study <input type="checkbox"/> Foster Home Study	Supervisory Services Requested: <input type="checkbox"/> Request Receiving State to Arrange Supervision <input type="checkbox"/> Another Agency Agreed to Supervise <input type="checkbox"/> Sending Agency to Supervise	Supervisory Reports Requested: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Upon Request <input type="checkbox"/> Other:
Name and Address of Supervising Agency in Receiving State:		
Enclosed: <input type="checkbox"/> Child's Social History <input type="checkbox"/> Court Order <input type="checkbox"/> Financial/Medical Plan <input type="checkbox"/> Other Enclosures <input type="checkbox"/> Home Study of Placement Resource <input type="checkbox"/> ICWA Enclosure <input type="checkbox"/> IV-E Eligibility Documentation		

Signature of Sending Agency or Person:	Date:
Signature of Sending State Compact Administrator, Deputy or Alternate:	Date:

SECTION IV - ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC

<input type="checkbox"/> Placement may be made	<input type="checkbox"/> Placement shall not be made
REMARKS:	
Signature of Receiving State Compact Administrator, Deputy or Alternate:	Date:

Sign & Date

DISTRIBUTION (Complete six (6) copies):

- Sending Agency retains a (1) copy and forwards completed original plus four (4) copies to:
- Sending Compact Administrator, DCA, or alternate retains a (1) copy and forwards completed original and three (3) copies to:
- Receiving Agency Compact Administrator, DCA, or alternate who indicates action (Section IV) and forwards a (1) copy to receiving agency and the completed original and one (1) copy to sending Compact Administrator, DCA, or alternate within 30 days.
- Sending Compact Administrator, DCA, or alternate retains a completed copy and forwards the completed original to the sending agency.

**INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN
REPORT ON CHILD'S PLACEMENT STATUS**

TO:

FROM:

SECTION I - IDENTIFYING INFORMATION

Child's Name: _____ Birthdate: _____
Mother's Name: _____ Father's Name: _____

SECTION II - PLACEMENT STATUS

Initial Placement of Child in Receiving State Date Child Placed in Receiving State: _____
Name of Resource: Evoke at Entrada
Address: 2711 Santa Clara Dr., Suite 400, Santa Clara, UT 84765
Type of Care: Outdoor Youth Treatment
 Placement Change Effective Date of Change: _____
Name of Resource: _____
Address: _____
Type of Care: _____

SECTION III - COMPACT PLACEMENT TERMINATION

Adoption Finalized In Sending State In Receiving State Court Order Attached
 Child Reached Majority/Legally Emancipated
 Legal Custody Returned to Parent(s) Court Order Attached
 Legal Custody Given to Relative Court Order Attached
Name: _____ Relationship: _____
 Treatment Completed
 Sending State's Jurisdiction Terminated with the Concurrence of the Receiving State
 Unilateral Termination
 Child Returned to Sending State
 Child Has Moved to Another State
 Proposed Placement Request Withdrawn
Name of Placement Resource: _____
 Approved Resource Will Not Be Used for Placement
Name of Approved Placement : _____
 Other (Specify): _____
Date of Termination: _____

SECTION IV - SIGNATURES

Person/Agency Supplying Information: _____ Date: _____
<Sign & Date>
Compact Administrator, Deputy or Alternate: _____ Date: _____

DISTRIBUTION (Complete four (4) copies of this form):
• Sending Agency retains a (1) copy and forwards completed original plus three (3) copies to:
• Sending Compact Administrator, DCA, or alternate retains one (1) copy and forwards two (2) copies to:
• Receiving Agency Compact Administrator, DCA, or alternate retains one (1) copy and forwards one (1) copy to the receiving agency

Fill in
Sect.
1

Sign
&
Date
here



PARENT/GUARDIAN CONSENT FORM

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 your child is enrolled at is a member of this organization.

WHAT IS THE PURPOSE OF THIS STUDY?

This study is designed to measure how your child is helped by his/her program. 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 perception of your child’s behavior and overall mental health
- Filling out these questionnaires will take you about 15 minutes
- You will be asked to fill them out at three different times:
 - 1) When your child is admitted to the program
 - 2) When your child graduates or leaves the program
 - 3) One year after your child graduates or leaves 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. The forms and instructions can also be mailed to you if necessary.
- If your child is 11 or over, they will be asked to fill out similar forms at these three times as well.

WHAT ARE THE POSSIBLE RISKS OF PARTICIPATING IN THIS STUDY?

There are no physical risks. You may feel some discomfort or embarrassment when you share personal information about your child or family. You should feel free to talk about any discomfort you feel with staff from your child’s program. You may withdraw from the study at any time.

WHAT ARE THE POSSIBLE BENEFITS OF PARTICIPATING IN THIS STUDY?

- This study is designed to help your child’s program get better at helping children. Your participation could help other children who will attend the program in the future.
- It is possible that the program will use the information gathered from you and/or your child to help them create a treatment plan
- *If you choose not to participate your child **will** still have access to every other aspect of the program and treatment that they would have otherwise.*

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

There is no cost to you

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 prejudice, penalty or loss of benefits to which you would otherwise be entitled.
- Your child will still have access to every other aspect of their program and treatment.



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 prejudice, penalty, or 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 child’s 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 or your child’s.

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

WHOM TO CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY

If you have any questions pertaining to the research you should feel free to contact your child’s program, or a UNH research coordinator at mgass@unh.edu, or at (603)862-2024.

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 below:

Client/Student Name

Parent/Guardian Signature

Date



cascades
Suite F-7
20332 Empire Avenue
Bend, OR 97703

entrada
2711 Santa Clara Drive
Santa Clara, UT 84765

admissions
t. 866.411.6600

evoketherapy.com 

Welcome to Evoke Therapy Programs,

We are excited to work with you and your child. Part of our commitment in supporting our families is providing insurance coverage assistance. Please understand you are responsible for paying the entire cost of Evoke Therapy Programs up front, and know we do not bill insurance companies directly. However, we do provide the resources for reviewing your insurance policy and support you in obtaining reimbursement from your provider. Informative to note, insurance companies' policies are ever-changing with regard to facility authorizations, mental health/substance abuse coverage, etc. The Mental Health Parity Addictions Equity Act and the Affordable Care Act have opened up new ways to have these types of claims properly reviewed and considered for full benefits.

To assist you in pursuing your benefits, we want to put you in contact with a healthcare advocate company that can advise you how to go about it. Denials Management, Inc. has been providing services to healthcare providers, families and facilities for over 25 years, and has helped thousands of families get their claims paid. They can help you set up a game plan to investigate your coverage and evaluate any claim issues that may arise, starting with a straightforward explanation of the complexities related to your claim, in terms you can understand.

The staff and resources at [DMI](#) offer a full array of assistance in verifying benefits, conducting policy reviews, and consulting with you about your insurance carrier's requirements for coverage of intermediate levels of care, billing, pre-authorization and appeal. Their initial registration fee of \$250.00 is paid for by Evoke.

To take advantage of your FREE consultation call with the President of DMI, reach out to her at:

Mary Covington, President
Denials Management, Inc.
4424 South 700 East, Suite 200
Salt Lake City, Utah 84107
1-866-322-0787 x 200

We appreciate the opportunity to work with you and your child. We hope this free review will aid you in recovering some of the expenses associated with our program. If you have any questions or concerns, please contact us for further guidance.

Thank you,

The Evoke Therapy Team

