

## IN BALANCE TRANSITIONAL LIVING

### Pre-Enrollment Requirements

This packet is required **only** if the applicant is accepted for enrollment. It should **not be completed** until the applicant's acceptance is confirmed and you are instructed to proceed with this stage of the admissions process by the Admissions Office. There are a number of procedures that must be completed prior to the student's enrollment. Please read the following instructions carefully

#### **Travel Arrangements**

Travel arrangements should not be made until you receive final confirmation of the student's acceptance for enrollment. The Admissions Director will advise you when all requirements have been met and recommend you proceed with travel arrangements. She will also want to review your proposed dates and flight specifics in order to assure that they are coordinated with school logistics. The Admissions Director will coordinate with the program and let you know when to confirm and pay for the student's airline tickets.

Several airlines offer service to Tucson, including United Airlines, Delta Airlines, Northwest Airlines, Continental Airlines, Southwest, and American Airlines. Students should fly into the Tucson International airport. Please try to schedule flights that arrive prior to 4:00pm. This allows residents plenty of time to travel to the program and complete all enrollment procedures on the day they arrive.

When you confirm the resident's reservation, please email this information to the Admissions Director so she can forward it to the appropriate person for pick-up arrangements.

#### **Medical and Dental Insurance**

Proof of medical insurance is required prior to the student's enrollment. *The Consent to Medical Treatment and Insurance Information* form must be completed and submitted to the Admissions Office, **along with a copy of the front and back of each insurance card** (Medical, Pharmacy, and Dental).

#### **Medications**

Residents currently taking prescription medications are required to bring a **minimum of a 30-day supply with them at the time of enrollment**. All medications must be in the original container with the original label. It is recommended that medications be placed in a carry-on bag in case checked baggage is lost or delayed. Please provide a list of all the medications the resident is taking along with any special instructions.

#### **Education Records**

The Academy requires educational records for each high school and college attended by the resident. Current credit transcript information is critical to developing an effective educational plan while at In Balance Living. Fill out the *Request for Educational Records* form and send or hand carry it to the last school attended by the student. If the student has attended more than one school, please make additional copies of this form and send one form to each school.

Educational records should be sent to the In Balance Admissions Office at the address on the form. Please remember that the faster we receive those records, the sooner we can begin planning an educational program for your son.

#### **Enrollment Agreement**

The *Enrollment Agreement* is a contract that details the terms of the resident's enrollment at In Balance Living and the parent's or financial sponsor's acceptance of financial responsibility for the services to be provided. Both custodial parents must sign this document if custody is shared. If the financial sponsor is someone other than the custodial parents, the financial sponsor and **each** custodial parent must sign the *Enrollment Agreement*. The attachments detailing the terms of payment may be signed by the financial sponsor only.

The Agreement provided is the standard contract required by In Balance Living. Its terms typically are not negotiable. Should you, however, request a modification to the Agreement, any changes must be reviewed by an attorney for In Balance Ranch Academy and may slightly delay the resident’s enrollment.

When the signed Agreement is received by the Admissions Office, an authorized representative will sign the document to execute the Agreement of behalf of In Balance Living. A copy of the fully executed agreement will be returned to you for your records.

**Resident Identification Card**

If the resident has an official identification card, please send the original along with them. If he does not have this, another picture identification can be substituted.

**Pre-enrollment Requirements Checklist**

This pre-enrollment checklist is provided as a convenience to assist parents in completing the pre-enrollment requirements. After completing the requirements, please return to this checklist and mark each item completed. The checklist will help ensure that you submit all information and documents required prior to enrollment.

<input type="checkbox"/>	<p>Travel Arrangements (see <i>Pre-enrollment Requirements Instructions</i>)</p> <p style="padding-left: 40px;">Travel arrangements have been made following review by admissions counselor.</p> <p style="padding-left: 40px;">Flight itinerary has been e-mailed or faxed to the Admissions Office</p>
<input type="checkbox"/>	<p>Completed Consent to Medical Treatment and Insurance Information form submitted to the Admission Office with the following attachments:</p> <p style="padding-left: 40px;">Copy of front and back of medical insurance card</p> <p style="padding-left: 40px;">Copy of front and back of pharmacy card</p> <p style="padding-left: 40px;">Copy of front and back of dental insurance card</p>
<input type="checkbox"/>	<p>Medication – 30 day supply of each prescribed medication</p>
<input type="checkbox"/>	<p>Educational Records – The Request for Educational Records form submitted to each high school the resident attended. The student’s educational records are:</p> <p style="padding-left: 40px;">Enclosed with this packet</p> <p style="padding-left: 40px;">Being sent directly to the Admissions Office by each school</p>
<input type="checkbox"/>	<p>Completed Enrollment Agreement submitted to Admissions Office</p> <p style="padding-left: 40px;">Signed appropriately as follows:</p> <p style="padding-left: 80px;">One Custodial parent only if custody is not shared and one parent has full custody</p> <p style="padding-left: 80px;">Both parents if custody is shared</p> <p style="padding-left: 80px;">Financial Sponsor if other than the parents</p>
<input type="checkbox"/>	<p>Resident’s Identification Card</p> <p>Other picture identification submitted</p>

**In Balance Living**  
**Resident and Family Information**

**Resident Information**

First Name		Middle Name	Last Name	
Nick Name			Date of Birth	Date of Enrollment (office use)
Is resident adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is resident a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does resident possess a current ID? <input type="checkbox"/> Yes <input type="checkbox"/> No		Additional ID:
Street Address		Social Security Number		Country of Citizenship (if other than USA)
City	State, Zip		Telephone Number	

**Custody Information:**

Biological Parent's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married		
Parent/Guardian Full Name	Relationship	Type of Custody <input type="checkbox"/> Joint <input type="checkbox"/> Full
Parent/Guardian Full Name	Relationship	Type of Custody <input type="checkbox"/> Joint <input type="checkbox"/> Full

**Father's Contact Information**

Father's Full Name (First Middle Last)		<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Social Security Number
Occupation		Business Telephone	Cellular Telephone
Street Address		Home Telephone	Date of birth
City	State, Zip	Fax Number	Email

Stepmother/Partner's Name (if applicable)		Social Security Number
Occupation	Cellular Telephone	Email

*Continued on next page*

**Mother's Contact Information**

Mother's Full Name (First Middle Last)		<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Social Security Number
Occupation		Business Telephone	Cellular Telephone
Street Address		Home Telephone	Date of birth
City	State, Zip	Fax Number	Email

Stepfather/Partner's Name (if applicable)		Social Security Number
Occupation	Cellular Telephone	Email

**Sibling Information**

Name of Sibling	Gender	Age	Relationship (Full, Half, Step)	Lives with (Mother, Father, Independent)

**Guardian Information (if other than biological parents)**

Guardian's Full Name (First Middle Last)		Relationship to Student	Social Security Number
Occupation		Business Telephone	Cellular Telephone
Street Address		Home Telephone	Other Telephone
City	State, Zip	Fax	Email

Guardian's Spouse/Partner (if applicable)		Date Married	Social Security Number
Occupation	Cellular Telephone	Email	

**Financial Sponsor Information (if other than parents)**

Sponsor's Full Name (First Middle Last)		Relationship to Resident	Social Security Number
Agency/Organization Name (if applicable)		Business Telephone	Cellular Telephone
Street Address		Home Telephone	Other Telephone
City	State, Zip	Fax Number	Email

**Emergency Contact Information (To Be Notified if Parents Cannot Be Reached)**

Name of Emergency Contact		Relationship to Student	
Street Address		Home Telephone	Cellular Telephone
City	State, Zip	Business Telephone	Email

**Referral Information – How did you hear about In Balance Living?**

*Circle One:*

*Educational Consultant*

*Boarding School*

*Relative Friend*

*Therapist/Counselor*

*Wilderness Program*

*Substance Abuse Program*

*Internet search or Web site*

*Parent of past/present In Balance Living?*

*Other: Please Specify*

**If referred by an individual, please provide the following information.**

Name of Referral Source	Title	Business Telephone
Organization Name	Fax	Email
Street Address	City	State, Zip

**If referred by another school or program, please provide the following information.**

Name of Referring School/Program	Contact Name (if applicable)
Street Address	Business Telephone
City	State, Zip

Student Information Provided by:

\_\_\_\_\_

**Name**

\_\_\_\_\_

**Signature**

## Current and Past Placements

### Current Placement

*Please list current out-of-home placements, including special purpose boarding schools, wilderness programs, psychiatric hospitalizations, treatment center, etc.*

Name of School/Program/Hospital		Contact Name	
Street Address		Telephone Number	Fax Number
City	State, Zip	Term of Enrollment/Placement From:                      To:	
Reason for enrollment/admission:			
Departure Circumstances:			

### Prior Placements

Name of School/Program/Hospital		Contact Name	
Street Address		Telephone Number	Fax Number
City	State, Zip	Term of Enrollment/Placement From:                      To:	
Reason for enrollment/admission:			
Departure Circumstances:			

Name of School/Program/Hospital		Contact Name	
Street Address		Contact Telephone Number	Contact Fax Number
City	State, Zip	Term of Enrollment/Placement From:                      To:	
Reason for enrollment/admission:			
Departure Circumstances:			



## IN BALANCE LIVING: PARENT REPORT

### **Presenting Problems and History**

Describe the reason for your son's admission to In Balance Living.

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When did this issue start?

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Was there a precipitating event (something that caused this)?

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How has this issue changed over time?

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Describe any changes (which have occurred over time) in your attitude about your son's challenges.

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**Emotional Expression:** (Please check each one which applies for your son)

- Over Controlled – feelings seldom openly displayed.
- Under Controlled – feelings displayed in impulsive and intense fashion.
- Emotional Expression varies quite a bit.
- Problems typically openly admitted.
- Problems typically denied.
- Other: Define: \_\_\_\_\_

**Behavior:** (Please circle each one that applies for your son)

Talks of suicide	Attempted suicide	Nightmares	Destructiveness	Impulsive
Agitated/Hyperactive	Disorganized	Skips school	Legal problems	Runaway
Perfectionist	Compulsive	Obsessive	Drinking alcohol	Gambling
Cigarettes	Sexually promiscuous	Self-Injurious Behavior (cutting, burning, etc)		
Other: Define: _____				

**Emotions**

**Current Problems/Symptoms:** Please check the box in front of each and every emotion that applies for your son. Also, please rate the intensity of that emotion for each item you have endorsed by circling the number. Use a 1 to 10 rating. 1 will indicate a very mild level of emotion. 10 will indicate an extreme level of emotion. **Base your rating on your son's behavior over the last six months.**

<input type="checkbox"/> Happy	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Sad	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Fearful	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Worried	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Anxious/ Tense	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Hopeless	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Easily Frustrated	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Angry	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Moody	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Defensive	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Hostile	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Rageful	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Other	1	2	3	4	5	6	7	8	9	10

Define Other : \_\_\_\_\_

**Cognition/Thinking** (Please circle each one which applies to your son)

- |                          |                 |                                    |
|--------------------------|-----------------|------------------------------------|
| Difficulty concentrating | Distractible    | Poor memory for day to day events  |
| Confused                 | Racing thoughts | Difficulty making simple decisions |

Other: Define: \_\_\_\_\_

**Social Functioning** (Please circle each one which applies for your son)

- |                       |                       |                   |                      |           |
|-----------------------|-----------------------|-------------------|----------------------|-----------|
| Isolates from peers   | Feels alone           | Dependent         | Feelings easily hurt | Fights    |
| Over-Responsible      | Lacks self confidence | Self-centered     | Holds Grudges        | Lies      |
| Uncooperative         | No respect for others | Bossy/Domineering | Argues               | Threatens |
| Irresponsible         | Resentful             | Suspicious        | Initiates conflict   | Shy       |
| Affiliates with Gangs |                       |                   |                      |           |

Other: Define: \_\_\_\_\_

**Stress-Related Health Functioning** (Please circle each one which applies to your son)

Complains of feeling sick      Fatigued      Eating more      Eating less      Tics      Headaches  
Compulsive exercise      More energy than normal      Less energy than normal      Tremors  
Sleeping more than normal      Sleeping less than normal      Weight gain      Weight loss  
Other: Define: \_\_\_\_\_

**What are your son's unique strengths and assets:**

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**Family Functioning**

Describe the current status of your son's relationship with his mother. How is this different from what it was six months ago?

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Describe current status of your son's relationship with his father. How is this different from what it was six months ago?

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Are there any major stressors affecting the family as a whole right now? Please describe.

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*If your son attended In Balance Ranch Academy, you do not need fill out developmental, family, or legal history as we already have the information on file.*

**Developmental History**

**Where was your son born?** \_\_\_\_\_

Where there any problems with the pregnancy or delivery?

yes  no If yes, please describe:

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

Full-Term baby?  yes  no

Was the baby unwanted by either parent, and if so, did that change?

\_\_\_\_\_

Was the baby breast or bottle fed?\_\_\_\_\_

Did the baby like to be held and cuddled?\_\_\_\_\_

**Have you noticed any difficulties with your son's social adjustment or development?**

Yes  No If yes, please describe:

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

**Has your son ever behaved in a way that frightened you:** (i.e., cruelty to animals, fire-setting, etc.)

Yes  No If yes, please describe:

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

**Describe any sexual abuse history of your son:**\_\_\_\_\_

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

**Describe any physical abuse history of your son:**\_\_\_\_\_

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

**Family History**

**Has anyone else in the family experienced emotional/psychiatric problems?**

Yes  No If yes, please describe:

1. Family Member\_\_\_\_\_

Problem/Treatment/Data\_\_\_\_\_

\_\_\_\_\_

2. Family Member\_\_\_\_\_

Problem/Treatment/Data\_\_\_\_\_

\_\_\_\_\_

**Has anyone in the family experienced problems with drugs or alcohol use?**

Yes  No If yes, please describe: Who? What type of problem? When did the problem occur?  
What treatment was utilized? What kind of success?

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**Briefly describe each parents' history** (include natural and step parents). Review where born and raised, brothers, sisters, highest grade completed and any significant information:

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**Has anyone in the family ever committed suicide?**  Yes  No

**Who?** \_\_\_\_\_

**When/How?** \_\_\_\_\_

**Has a friend of your son's ever committed suicide?**  Yes  No

**Who?** \_\_\_\_\_

**When/How?** \_\_\_\_\_

**Legal Information**

**Has your son ever been involved with the legal authorities?** (CPS, Police, Juvenile Court)

Yes  No If yes, please describe:

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**Is he currently under court supervision?**  Yes  No If yes, please describe:

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\_\_\_\_\_  
Name Relationship to Patient Date

## Medical History

### Current Health Status

Current or Chronic Conditions Affecting the Student (Please Be Specific) <input type="checkbox"/> None Known
Known Activity Limitations (Please Be Specific) <input type="checkbox"/> None Known

### Allergies (Please provide specific allergies, severity of each reaction, date of last reaction)

Medication Allergies <input type="checkbox"/> None Known <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Iodine <input type="checkbox"/> Other (specify)
Food Allergies <input type="checkbox"/> None Known
Insect Bite Allergies <input type="checkbox"/> None Known <input type="checkbox"/> Bees <input type="checkbox"/> Wasps <input type="checkbox"/> Other (specify)                      Is Kit Required <input type="checkbox"/> Yes <input type="checkbox"/> No
Airborne Allergies (Hay fever, Grasses, Dust, Animal Hair, Etc.)
Other Allergies

### Current Medications

Name of Medication	Date Prescribed	Dosage/Schedule	Reason for Medication

### Authorization for Release of Medical Information

The undersigned hereby attest that the medical information provided above is accurate and complete. We also authorize and consent to the release of any and all information about the student's medical or dental history, including student's medical and dental records, to any facility providing medical care or dental care and to emergency transport professionals.

Print Name	Signature of Parent/Guardian	Date Signed

## Insurance Information

**Please provide copies of the front and back of each insurance card documented below!!!**

### Consent to Medical Treatment and Insurance Information

I/We authorize and consent to any medical or dental procedure undertaken for Student's health and well being. This authorization includes, but is not limited to, examinations, x-rays, inoculations, vaccinations, medical, dental, or surgical procedures administration of local and/or general anesthetics and/or hospital care. I understand that none of the previously described treatment will be undertaken without the advice of a physician or dentist licensed to practice medicine in the geographic area where the services are rendered.

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

### Medical Insurance (submit copy of front and back of insurance card with this form)

Insurance Company (Please Print)			
Street Address	City	State	Zip
Insurance Provider Telephone	Fax		
Policyholder Name	Policyholder's Social Security Number		
Policy Number	Group Number (if Applicable)		
Policyholder employer ( if group policy)	Policyholder's Date of Birth:		
Coverage (emergency, mental health, pharmacy, etc.)			

### Dental Insurance (Submit a copy of front and back of insurance card with this form)

Insurance Company (Please Print)			
Street Address	City	State	Zip
Insurance Provider Telephone	Fax		
Policyholder Name	Policyholder's Social Security Number		
Policy Number	Group Number (if Applicable)		
Policyholder Employer (if group policy)	Policyholder's Date of Birth:		
Coverage (emergency, preventative, cosmetic, etc.)			

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Date

## Request for Educational Records

Student Name (First Middle Last)	Date of Birth	Social Security Number
Street Address	City	State, Zip

Dear Registrar,

The above named student is being enrolled at In Balance Living. Prior school records are needed to assist in academic planning. Please send copies of the following documents to the address at the bottom of the page:

- ◆ Verification of dates of enrollment and withdrawal
- ◆ Reason for withdrawal from your school and withdrawal grades
- ◆ Current credit transcript
- ◆ Educational evaluations, achievement test results, special education assessment
- ◆ IEP, if applicable
- ◆ Disciplinary records
- ◆ Health and immunization records
- ◆ Other records relevant to academic planning
- ◆ Graduation requirements for your school

Please do not send the original academic records as we would like it to remain on file at your school. Thank you for your prompt attention to this request.

### Authorization for Release of Information

The undersigned hereby grant permission to release all available school records for the above named student to the Registrar of In Balance Ranch Academy. Permission is granted to release the following records; official transcript of credit; withdrawal grades; special education records; IEP, educational assessment results; health records; immunization records; disciplinary reports; counseling information and any records pertaining to psychiatric or psychological evaluation of the student.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_

Date

### Send records to the following address:

*In Balance Living  
6107 East Grant Road  
Tucson, Az 85712*

*Phone: 520-722-9631  
Fax: 520-722-9676*

## Academic History

### Academic Status (Please attach copies of academic transcripts)

Current Grade Level	Grade Point Average (GPA):
Credits earned toward graduation:	Remaining credits required for graduation:
Is student following a college preparatory curriculum? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the student taken the college entrance examinations (ACT/SAT)? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Learning Differences (Please attach copies of evaluations, IEP or other related documents)

Does student have a preferred learning style (written, oral, graphic visuals, experiential, tactile)?		
Does student have any known learning differences? If yes, specify type and attach copy of evaluation (if available) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has student ever been diagnosed with any attention issues (ADD, ADHD)? If yes, specify type and attach a copy of evaluation (if available) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has student ever been prescribed medication to assist with attention difficulties? If yes, please specify name of medication. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there any special needs or educational considerations required for the student? If yes, please explain <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does student have an Individualized Education Plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please attach a copy of IEP	Date Implemented	Date last modified

### School Behavior

Describe Student's Feelings about School
Does Student have a history of school behavior problems? If yes, please explain. <input type="checkbox"/> Yes <input type="checkbox"/> No
Has student ever been expelled from school? If so, please explain circumstances <input type="checkbox"/> Yes <input type="checkbox"/> No

### Educational Interests, Accomplishments and Goals

Describe student's educational interests and any special accomplishments.
Describe any extra-curricular activities in which the student has participated.
Describe your goals/hopes for the student following completion of High School.

**Resident Name:** \_\_\_\_\_

The undersigned does hereby apply for admission as a patient at In Balance Living. By accepting the patient at the facility, In Balance Living does not warrant or agree to effect a cure, but does agree to accord the patient such medical care and treatment for alcoholism/addiction and/or behavioral health disorders as will provide him/her the maximum opportunity for recovery. The practice of medicine and the treatment of addiction are not exact sciences, and no guarantee can be made as to the results of the treatment.

The following conditions and provisions shall govern the treatment, care and accommodations provided to all students at the facility.

**I agree to conform to the rules and regulations of In Balance Living.**

**1. Consent to Care and Treatment:** By accepting these Conditions of Admission, the resident’s parent or guardian consents to such medical care and treatment as is deemed necessary or helpful by In Balance personnel in their efforts to effect treatment.

Parent/Guardian/ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**2. Grievance Procedure:** I acknowledge that I have been informed of and understand the In Balance Living Patient Grievance Procedure.

Parent/Guardian/Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**3. Consent to Search:** I authorize In Balance Living personnel, at any time, to conduct a thorough search of all my property and my room, and, if necessary, of my person, for any illegal or controlled substances or contraband. I further authorize In Balance Living personnel to destroy any confiscated items in accordance with In Balance Living Policies.

Parent/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**4. Damage:** Any damage to In Balance Living property caused by the resident will be billed to resident’s account at the cost of repair or replacement.

Parent/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**5. Against Medical Advice-AMA Discharge:** In the event that the student requests discharge **AMA**, In Balance Living requires 24-hour notice from the resident’s family to allow for continuing care/discharge planning to be implemented prior to discharge. Any outstanding balances must be cleared prior to discharge. There will be no refunds.

Parent/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**6. Medical Services:** For any medical needs that arise while the student in at In Balance Living, resident agrees to make individual, separate arrangements with the provider of medical services. Selection of providers and scheduling will be made by In Balance Living staff, but when possible, the specific requests of the resident will be respected. (In Balance Living may directly pay for the bill, but the bill will be charged to the parent’s account)

Parent/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**7. All Behavioral Health services will be provided by In Balance Counseling, Inc**

Parent/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**8. Financial Responsibility:** The undersigned agrees whether he/she signs as agent or as resident, that in consideration of the admission of student in In Balance Living and of the services to be rendered to the resident, he/she hereby individually obligates himself/herself to pay the account of In Balance Living in accordance with the regular rates and terms of In Balance Living. The undersigned understands that In Balance Living may request financial and credit information from various sources including, without limitation, credit reporting bureaus, and consents to the release of any and all such information. The undersigned authorizes and consents to the release of any and all information required for purposes of collecting any money due on resident's account to any spouse, guarantor, collection agency, agent of In-Balance Living, attorney, or any other person or entity who is, or may be liable for all or a portion of the uncollected amount owed by undersigned as a result of a resident's treatment. All financial arrangements are confidential between In Balance Living, resident, guarantor, and payer. Balance of the total bill is due at the time of discharge. All accounts not paid within 30 days of discharge shall bear interest at 15% per annum. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fees and collection expenses. If a credit balance is generated on an account, an appropriate refund will be made after the cause of the refund is determined and the payee is determined. Refunds to student and/or their guarantors will be processed within 30 days of the date the credit balance was created and refund to insurers or other third party payers will be processed within 90 days of the date the credit balance was created.

Parent/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Rates:** Charges to students include, but are not limited to the following.

**Monthly Tuition Payment \$5,900/month + one time activity/equipment fee \$500**

Parent/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned acknowledges that In Balance Living is a 6-12 month program and hereby agrees to at least a **minimum** of 6 month's stay for their son at In Balance. No refunds will be issued if the Resident does not complete the program, except for unforeseen medical purposes that may cause a discharge from the program.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned accepts the terms hereof, certifies that he/she has read the foregoing, has received a copy hereof, and is the parent/guardian of the resident.

Date of Admission:	Date of Signature:
Printed name of Resident:	Printed Name of Parent/Guardian:
Signature of Parent/Guardian	

**Behaviors That Can Result in Early Discharge or Transfer**

In Balance Living’s goal is that you have a successful treatment experience. We want to inform you that there are behaviors that could interfere with your recovery and could result in discharge or transfer. We ask that you read and understand what those behaviors may be. We encourage your questions. In Balance Living wants to ensure that all residents are provided with a safe environment that is conducive to recovery.

The following is a list of behaviors that may lead to discharge or transfer to another facility:

1. The use or supplying of mood altering drugs or illegal substances.
2. Non-compliance with medical care and/or clinical treatment recommendations. Not meeting program expectations or requirements.
3. Fraternizing; sexual contact with another resident.
4. Any violent behavior. This behavior includes explosive outbursts, hitting, slapping, kicking, verbal threats, and intimidation or property damage.
5. Possession of weapons
6. Leaving the In Balance Living Campus without staff knowledge and permission.

**I have reviewed the above behaviors and understand that if I behave in any of the ways described, I may be discharged.**

**Resident Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Staff Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_