



IN BALANCE

TRANSITIONAL LIVING

In Balance Living Application Packet-To be Mailed

2011

Please take the time to read this in its entirety, as we will assume you are familiar with all the information included in this packet. If you have any questions please contact Betsy Barrasso at (520)722-9631. Thank you. When the entire packet is complete please mail to In Balance. MAILING ADDRESS: 6107 E. Grant Rd, Tucson, AZ 85712

Resident Name: _____ DOB: _____

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Resident & Family Information

RESIDENT INFORMATION:

| | | | |
|--|---|---|---------------------------------|
| First Name | Middle Name | Last Name | |
| Nick Name | | Date of Birth | Date of Enrollment (office use) |
| Is Resident Adopted? [] Yes [] No | Is Resident a U.S. Citizen? [] Yes [] No | Does Resident possess a current passport? [] Yes [] No | Passport Expiration Date: |
| Street Address | | Resident's Social Security Number | Country of Citizenship |
| City | State, Zip | Telephone Number | |

CUSTODY INFORMATION for minors (Please include copies of all legal documents related to custody):

| | | | |
|--|---------------------------------------|---------------------------------------|--|
| Biological Parent's Marital Status: [] Married [] Separated [] Divorced [] Never Married | List of all legal documents included: | | |
| Parent/Guardian Full Name | Relationship | Type of Custody [] Joint [] Full | Resident can be released into my custody [] Yes [] No |
| Parent/Guardian Full Name | Relationship | Type of Custody [] Joint [] Full | Resident can be released into my custody [] Yes [] No |

FATHER'S CONTACT INFORMATION:

| | | | |
|--|-------------------------|------------------------|-------|
| Father's Full Name (First Middle Last) | [] Living [] Deceased | Social Security Number | |
| Occupation and Employer | Business Telephone | Cellular Telephone | |
| Street Address | Home Telephone | Date of birth | |
| City | State, Zip | Fax | Email |

STEPMOTHER'S CONTACT INFORMATION:

| | | | |
|---|--------------------|------------------------|-------|
| Stepmother/Partner's Name (if applicable) | | Social Security Number | |
| Employer/Occupation | Business Telephone | Fax | Email |

MOTHER'S CONTACT INFORMATION:

| | | | | | |
|--|------------|-------------------------|--|------------------------|--|
| Mother's Full Name (First Middle Last) | | [] Living [] Deceased | | Social Security Number | |
| Employer and Occupation | | Business Telephone | | Cellular Telephone | |
| Street Address | | Home Telephone | | Date of birth | |
| City | State, Zip | Fax | | Email | |

STEPFATHER'S CONTACT INFORMATION:

| | | | | | |
|---|--------------------|------------------------|-------|--|--|
| Stepfather/Partner's Name (if applicable) | | Social Security Number | | | |
| Employer/Occupation | Business Telephone | Fax | Email | | |

SIBLING INFORMATION:

| Name of Siblings | Gender | Age | Lives with (Mother, Father, Independent) |
|------------------|--------|-----|--|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

GUARDIAN INFORMATION for minors (if other than biological parents):

| | | | | | |
|---|--------------------|--------------------------|--|------------------------|--|
| Guardian's Full Name (First Middle Last) | | Relationship to Resident | | Social Security Number | |
| Employer and 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 | |
| Employer/Occupation | Business Telephone | 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 Resident | |
| Street Address | | Home Telephone | Cellular Telephone |
| City | State, Zip | Business Telephone | Email |

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

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

DEMOGRAPHIC INFORMATION AND PHYSICAL DESCRIPTION

| | | | |
|----------------------------|----------------|----------------------------|--------------------------------|
| Religious Preference | Race/Ethnicity | Resident's Native Language | Other Languages spoken in home |
| Height | Weight | Eye Color | Hair Color |
| Pant Size (waist & length) | Shirt Size | Shoe Size | Boot Size |

Enrollment Agreement/Conditions of Admission (Confidential)

Resident's Name (Last, First Middle)

Date of Birth

The undersigned does hereby agree to have my son as a Resident at In Balance Living. By accepting the Resident at the facility, In Balance Living does not warrant or agree to affect a cure, but does agree to accord the Resident such medical care and treatment for alcoholism/addiction and/or behavioral health disorders as will provide him 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 Residents 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: _____ Resident Initials (if over 18) _____ Date: _____

2. **Enrollment Agreement/Refund Policy:** The undersigned acknowledges that In Balance Living is a 6-8 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 or if the resident leaves the program without parental consent.**

Parent/Guardian Initials: _____ Date: _____ Resident Initials (if over 18) _____ Date: _____

3. **Client Rights/ Grievance Procedure/ Complaint Investigation/HIIPA Rights:** I acknowledge that I have been informed of and understand the In Balance Living policies concerning Client Rights, Grievance Procedure, Complaint Investigation, and HIPPA Rights. (see Policies 2.30, 2.40, 2.45, & 2.50 in the "To be Kept," packet)

Parent/Guardian Initials: _____ Date: _____ Resident Initials (if over 18) _____ Date: _____

4. **Consent to Search:** I authorize In Balance Living personnel, at any time, to conduct a thorough search of all my son's property and his room, and, if necessary, of his 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: _____ Resident Initials (if over 18) _____ Date: _____

5. **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: _____ Resident Initials (if over 18) _____ Date: _____

6. **Against Medical Advice-AMA. Discharge:** In the event that the Resident's parent or guardian requests discharge against medical advice, In Balance Living requires a 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: _____ Resident Initials (if over 18) _____ Date: _____

7. **Medical Services:** For any medical needs that arise while the Resident is at In Balance Living, parent/guardian 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, and when possible, the specific requests of the Resident will be respected. (In Balance Living will neither directly pay for nor bill for Resident medical services given by an outside provider, pharmacy or other medical supplier.)

Parent/Guardian Initials: _____ Date: _____ Resident Initials (if over 18) _____ Date: _____

8. **All Behavioral Health services will be provided by In Balance Counseling, Inc. We do not participate in any insurance billing.**

Parent/Guardian Initials: _____ Date: _____ Resident Initials (if over 18) _____ Date: _____

9. **Financial Responsibility:** The undersigned agrees whether he/she signs as agent or as Resident, that in consideration of the admission of Resident 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, 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 Resident 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.

Rates: Charges include, but are not limited to the following: once a week individual session, twice a week intensive outpatient groups (21 groups total), and once a month family session.

| | |
|---------------------------------------|-------------------|
| Monthly Cost: | \$5,900.00 |
| One time Equipment Rental Fee: | \$ 500.00 |

Parent/Guardian Initials: _____ Date: _____

10. **Credit Card:** The undersigned agrees that this credit card may be charged for delinquent balances of 60 days or more. In the event this credit card is used to pay a delinquent account, a \$100.00 processing fee will also be charged on this credit card. The undersigned also agrees that this credit card may be charged for any expenses not covered by the tuition for In Balance Living.

Please circle one of the following cards:

Visa MasterCard Discover

(Sorry at this time we are not accepting American Express)

Credit Card #: _____ Exp. Date: _____/_____/_____ Sec. Code: _____

Parent/Guardian Initials: _____ Parent 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.

Resident's Name (Last, First Middle)

Date of Birth

Date of Admission

Print Name

Signature of Parent/Guardian

Date

Print Name

Signature of Resident (if 18 or older)

Date

Consent for Treatment

(In Balance Staff Signature can be acquired once packet is shipped to In Balance)

I, _____, parent/legal guardian of _____, provide consent for my son to receive behavioral health services at In Balance and hereby authorize In Balance to provide such services for my son.

I understand and accept full responsibility for financial obligations incurred for services provided. I have been informed of all fees that I may incur while my son is in treatment and have also been given a copy of In Balance’s fee refund policy.

I further agree that this authorization and delegation of authority shall be in full force and effect until revoked by me in writing and such revocation has been delivered to In Balance or until the client is discharged, whichever occurs first.

I have received a copy of Client Rights, Grievance Procedure, and HIPPA guidelines and the following agency phone numbers and addresses (please see “Policies and Procedures 2.30):

- Office of Behavioral Health Licensing
- Dept. Div. of Behavioral Health Services
- Human Rights Advocates
- AZ Department of Economic Security for Adult Protective Services
- Son Protective Services
- Regional Behavioral Health Authority
- Community Partnership of Southern AZ

This authorization and consent for treatment has been read carefully by me. I certify that I understand its contents, its meaning and its effect.

Print Name

Signature of Parent/Guardian

Date

Print Name

Signature of Resident (if 18 or older)

Date

Print Name

Signature of In Balance Staff

Date

Credit Card Payment and Guarantee Form

OPTIONAL: Fill this out only if you wish to pay your monthly payment via Credit Card, otherwise please go to the next page

Resident's Name (Last, First Middle)

Guarantor Name (Last, First Middle)

Address

City

State/Zip

Home Phone:

Cell Phone:

The undersigned agrees to guarantee payment for services rendered at In Balance, for the Resident listed above.

We do not accept American Express; **only** Visa, MasterCard or Discover Card are accepted.

Please circle one of the following cards:

Visa MasterCard Discover

Credit Card #: _____ Exp. Date: ____/____/____ Sec. Code: _____

Customer Code: _____

(for business acct. only)

Billing Address: _____ City: _____ State/Zip: _____

Phone #: _____

(There is a \$100.00 convenience fee per transaction for this service. Your account will be charged at the beginning of each month.)

I agree to the above terms and agree to have my credit card charged each month for services provided as well as the convenience fee

Print Name

Signature of Cardholder

Date

Waiver of Claims and Release of Liability

(Witness Required)

Resident's Name (Last, First Middle)

Date of Birth

- Waiver of Claims and Release of Liability:** The undersigned Resident or the undersigned legal guardian of the Resident, on behalf of myself and my family members, does hereby release In-Balance Living, Inc., its parent corporations, agents, employees, and contractors from any liability of whatever kind and nature for injuries, whether physical or emotional, temporary or permanent, which I or my family may sustain as a result of my participation in any athletic or sporting events, physical exercise or therapy modalities; the use of any motor vehicles and the use of any treatment center facilities such as the swimming pool, tennis court, etc., during my stay at In Balance Living, Inc., and expressly assume the risk for my participation in all of the above or similar activities.
- Photograph Consent:** I, the undersigned, do hereby consent for In Balance Living to take my photograph which will be used for identification purposes. Adolescent Residents involved in art therapy may be videotaped during session. I/We give permission for my/our son to be videotaped during art therapy and further give permission for his art work to be displayed within the facility and on the web site. I/We further give permission for written material generated by my/our son in the poetry and recovery modality to be published anonymously.
- Physical Activity:** Disclosure: In Balance Living programs involve a variety of activities that often include warm ups, games, group initiative problems, low ropes course elements, equestrian activities and karate. The level of participation in a program activity is at all times completely up to the individual's choice. Although appropriate safety standards are maintained, there is a risk that must be assumed by each participant that he may suffer an emotional or physical injury, disability or death.

Release of Liability: I understand that parts of the In Balance Living program may be physically or emotionally demanding. I affirm that my son's health is good, and that he is not under a physician's care for any undisclosed condition that bears upon his fitness to participate in activities. I understand that each participant must assume the risk of physical injury that could result from any of these activities. I release In Balance Living, and its staff members, from all liability for any injury to me, any member of my family, or my son from participation in In Balance Living activities. I understand that these terms shall serve as a release of liability for my heirs, executors, administrators and all members of my family. I have carefully read this Disclosure and Release of Liability and fully understand its content.

Parental Waiver of Claims: Parental permission must be secured for participants who are not of legal age (18 years). If you are not yet classified as legal adult, your parent(s) or legal guardians(s) must complete the following:

I/We _____ (parent's or guardians' name(s)) give my permission for my/our son to participate in the In Balance Living program. Should my/our son become injured, I/we authorize that the trip leader(s) secure emergency medical services to aid my/our son, if in their judgment such services are necessary. I/We agree to incur any additional expenses associated with such action. As parents/guardians, I/we have decided (with or without medical advice) that my/our son is physically, mentally, and socially able to participate, and I/we acknowledge that any medical or accident insurance we consider necessary will be my/our responsibility to locate and purchase. Furthermore, I/we have read all sections of this form and hereby release In Balance Living and its employees from liability for any damages, injuries, or losses that may occur while said son is participating in this In Balance Living program.

Print Name

Signature of Parent/Guardian

Date

Print Name

Signature of Resident (if 18 or over)

Date

Print Name

Signature of Witness

Date

Consent to Medical Treatment

(Notary Required)

Note: This completed form along with a copy of the front and back of all insurance cards (medical, pharmacy, dental) must be submitted to the Admissions Office prior to the Resident’s enrollment. This form and the Consent to Emergency Services form immediately following this are the only documents that need to be notarized in this packet.

Resident’s Name (Last, First Middle)

Date of Birth

I/We authorize and consent to any medical or dental procedure undertaken for Resident’s health and wellbeing. 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 Name

Signature of Parent/Guardian

Date

To be filled out by a Public Notary:

Subscribed and sworn before me this _____ day of _____, 20_____

Print Name

Signature of Notary

State of: _____

County of: _____

Stamp:

Consent to Medical Emergency Services

(Notary Required)

Resident's Name (Last, First Middle)

Date of Birth

A. MEDICAL AUTHORIZATION

All medical care provided at IN BALANCE LIVING is designed to meet the Resident's needs and to provide optimum health. Upon admission, the nursing department reviews the Resident's health and medical history, identifies current medical needs, and helps facilitate ongoing medical services. Please answer the following questions.

1. Do you authorize IN BALANCE LIVING staff to supervise self-administration of authorized prescription medication to your son? Yes No

B. CONSENT FOR EMERGENCY CARE

I/WE the parent/legal guardian of _____, expressly agree that in the case of an emergency, in the event the above-named Resident may be injured or stricken ill while participating in an interscholastic activity or any other activity, do hereby authorize the hospitalization, surgical treatment, surgery and/or anesthesia for the above named, if in the opinion of an attending physician, any or all thereof warranted, and we hereby authorize any member of IN BALANCE LIVING professional staff to execute the necessary consent thereto.

I/WE the parent/legal guardian of _____, further expressly agree that all medical costs will be undersigned's financial responsibility. Any medical charges will be discussed with the parent/legal guardian prior to service being rendered unless there is an emergency in which the parent/legal guardian will be notified as soon as possible.

PARENT/GUARDIAN INFORMATION:

Mother's Name (Last, First Middle)

Home Phone:

Work Phone:

Cell Phone

Address

City

State/Zip

Father's Name (Last, First Middle)

Home Phone:

Work Phone:

Cell Phone

Address

City

State/Zip

IN CASE OF AN EMERGENCY AND THE PARENT/GUARDIAN CANNOT BE LOCATED, PLEASE CONTACT:

Name (Last, First Middle)

Relationship

Home Phone:

Cell Phone:

PRIMARY CARE PHYSICIAN:

Doctor's Name (Last, First Middle)

Doctor's Phone

Print Name

Signature of Parent/Guardian

Date

Print Name

Signature of Resident (if 18 or older)

Date

To be filled out by a Public Notary:

Subscribed and sworn before me this _____ day of _____, 20_____

Print Name

Signature of Notary

State of: _____

County of: _____

Stamp:

Behaviors That Can Result in Early Discharge or Transfer

(Resident Signature can be acquired once he is at In Balance Living)

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 (which include tobacco products).
2. Non-compliance with medical care and/or clinical treatment recommendations. Not meeting program expectations or requirements.
3. Fraternalizing; 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. Stealing
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. I understand if I am discharged from the program or chose to leave against medical advice, I will not be allowed back on the property

Print Name

Signature of Resident

Date

Print Name

Signature of Parent/Guardian

Date

Authorization of Disclosure Notification Consent Form

Resident's Name (Last, First Middle)

Date of Birth

If my son is under 18, I, _____, give my authorization for In Balance Living to:

1. **Receive** mail for my son from the following people (please print):

- | | |
|----------|-----------|
| 1) _____ | 6) _____ |
| 2) _____ | 7) _____ |
| 3) _____ | 8) _____ |
| 4) _____ | 9) _____ |
| 5) _____ | 10) _____ |

2. **Do not receive** mail for my son from the following people (please print):

- | | |
|----------|-----------|
| 1) _____ | 6) _____ |
| 2) _____ | 7) _____ |
| 3) _____ | 8) _____ |
| 4) _____ | 9) _____ |
| 5) _____ | 10) _____ |

This authorization may be revoked by me at any time except to the extent that action has been taken in reliance hereon. This authorization (unless expressly revoked earlier) expires upon my son's discharge from In Balance Living.

Print Name

Signature of Parent/Guardian

Date

Outward Bound Experience

I, _____, parent/guardian of _____, hereby acknowledge that the In Balance program offers a variety of outward bound experiences during the program. I understand these experiences may be demanding mentally, emotionally and physically. I acknowledge that with all outdoor activities, the potential exists for personal injury to my son. I hereby waive and release all rights and claims which I may have against In Balance, its associates, employees and agents for any and all injuries or damages suffered by my son during any outward bound experience, EXCEPT for those injuries or damages caused by the gross negligence or willful misconduct of In Balance, its associates, employees or agents.

I further acknowledge and agree that:

1. If required, I have completed the In Balance Medical Review and the information I provided was complete and accurate. I recognize that failure to disclose complete and accurate information could result in serious harm to my son and/or fellow participants.
2. In Balance has my consent, in the case of any emergency, to release all medical information and accident report form to insurance companies, my employer and any other agency deemed appropriate by In Balance.

Print Name

Signature of Parent/Guardian

Date

Print Name

Signature of Resident (if 18 or older)

Date

Authorization for the Obtention and Release of Information to Kevin Leehey, M.D.

(If your son is currently on any medications, including but not limited to, psychotropic medications and will need to visit a psychiatrist during his stay at In Balance, please fill this form out appropriately. Otherwise, please skip this form and continue on to the next one)

Resident's Name (Last, First Middle)

Date of Birth

Psychiatric Professional that In Balance Refers to:

Offices of Kevin Leehey, M.D.
 Son, Adolescent, and Adult Psychiatry
 ABPN Board Certified
 1980 E. Ft. Lowell Road, Suite 150
 Tucson, Arizona 85719
 Phone: (520) 296-4280 | Fax: (520) 296-3835

I, _____, authorize In Balance to: (please mark both) [] Obtain & [] Release medical, psychological, educational, legal and social information pertaining to the above mentioned individual.

This release shall be effective for one year from date of signature, until the _____ day of _____, 20____.

In Balance is hereby released from any and all legal liability that may arise from the obtention or release of the information requested. I certify that this request for obtention or release has been made freely, voluntarily, without coercion and that the information given is accurate to the best of my knowledge.

I understand that my records are protected under federal regulations 42 CFR Part2, governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically in one year from the time this form is signed.

The undersigned hereby grants permission to obtain or release all information for the above named Resident to/from the Offices of Kevin Leehey, M.D. Permission is granted to release or obtain the following records: health records; immunization records; disciplinary reports; counseling information; psychiatric notes; changes in medication; and any records pertaining to medical, psychiatric or psychological evaluation of the Resident.

Print Name

Signature of Parent/Guardian

Date

Print Name

Signature of Resident (if 18 or older)

Date

Print Name

Signature of Witness

Date

In Balance Living Activity Clearance

Resident's Name (Last, First Middle)

Date of Birth

The above named Resident is applying to enroll or is enrolled in In Balance Living located in Tucson, AZ. Many of the activities are adventure oriented and may be physically demanding. In addition to physical education and individual or team sports, activities may include, by way of example and not limitation, camping, hiking, running, climbing, rappelling, swimming, surfing, kayaking or horseback riding. Residents may be required to pull, lift or carry heavy equipment and may be exposed to changes in temperature and/or elevation.

It is very important that In Balance know whether the Resident's health might require any limitations in activity level or special medical assistance.

Print Name

Signature of Physician

Date