COPPER HILLS YOUTH CENTER

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ADMISSION RECORD

Date: **Physician:** **Unit:**
Time: **Therapist:** **Legal Status:**

RE-ADMISSION? YES NO **Date of Last Admit** _____

PLEASE PRINT CLEARLY – ALL INFORMATION MUST BE COMPLETE

RESIDENT INFORMATION

Last Name:	First Name:	Middle Initial:	Medicaid #	Social Security #

Address: (street, city, state, zip)	Phone Number:

Age:	Date of Birth:	Sex:	Race:	Religion:	Grade:

GUARDIAN INFORMATION

Parent/Guardian Name:	Relationship:	Custody of Resident? YES NO	Account Guarantor? YES NO	Home # / Cell #

Address: (street, city, state, zip)	Social Security #	Employer:	Work #
	Date of Birth:	Email:	

Parent/Guardian Name:	Relationship:	Custody of Resident? YES NO	Account Guarantor? YES NO	Home # / Cell #

Address: (street, city, state, zip)	Social Security #	Employer:	Work #
	Date of Birth:	Email:	

REFERRAL INFORMATION

Referral Source: (Name, Address, Telephone)	JPO: (Name and Number)	GAL: (Name and Number)

EMERGENCY NOTIFICATION (other than guardian)

Name and Address:	Relationship:	Phone Number(s):

INSURANCE INFORMATION *(must be complete)*

Primary Insurance:	Insurance Address:		Name of Policy Holder:
Policy Number:	Group Number:	Insurance Phone Number:	

Secondary Insurance:	Insurance Address:		Name of Policy Holder:
Policy Number:	Group Number:	Insurance Phone Number:	

5899 West Rivendell Drive, West Jordan, UT 84081 • (801) 561-3377 *phone* • (801) 214-2931 *fax*

COPPER HILLS YOUTH CENTER

Kids Behavioral Health, LLC
Notice of Privacy Practices
Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. Many of our doctors follow the practices contained within this Notice.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI: FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

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SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- Your information may be included in a patient directory that is available only to, those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gunshot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

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- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH

You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to:
  200 Independence Ave., S.E.,
  Washington, D.C.20201 or call
  1-877-696-6775.

CONTACT FOR ADDITIONAL INFORMATION

If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

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COPPER HILLS YOUTH CENTER

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we
will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective Date: This notice takes effect on
September 23, 2013 Version # 1

ACKNOWLEDGEMENT OF PERSONAL REPRESENTATIVE

I acknowledge that on the date indicated below, I represented that I am the personal representative of the resident named below and that I was provided a paper copy of the Notice of Privacy Practices of Kid's Behavioral Health, LLC on behalf of this resident. I understand that this Notice describes how medical information about the resident may be used and disclosed and how I can get access to this information. I understand that I should review the Notice of Privacy Practices carefully.

SIGN

Name of Representative	**Signature of Representative**	**Date**

Name of Resident	**Relationship of Representative to Resident**

Copper Hills Representative	**Date**	**Time**

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE OR IF YOU WOULD LIKE ADDITIONAL INFORMATION, OR IF YOU WISH TO FILE A COMPLAINT:

Address correspondence or telephone calls to:
PRIVACY OFFICER
5899 West Rivendell Drive
West Jordan, UT 84088
(801) 561-3377

COPPER HILLS YOUTH CENTER

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CUSTODIAL VERIFICATION

****REQUIRED** Must provide proof of custody/guardianship upon admission.**
This may be depicted in a birth certificate, divorce decree, court order, or adoption agreement.

PARENT(s)

We, _____hereby state to Copper Hills
Print Names of Parent(s)
Youth Center that we are the natural and/or adoptive parents of _____.
Name of Resident

CUSTODIAL PARENT OR LEGAL GUARDIAN:

I, _____ herby state to Copper Hills Youth Center that I have

_____ **JOINT** _____ **SOLE** _____ **LEGAL CUSTODY**

of _____.
Print name of Resident

Within 48 hours, I hereby agree to provide legal proof of documentation that shows the above stated custody relationship. A signed copy of the divorce decree will suffice. If documentation is not presented within 48 hours, I authorize Copper Hills Youth Center to obtain proof of custody through the courts at my expense.

_____ **Date of Divorce**

_____ **City/State/County of Divorce Record**

Additionally, I authorize Copper Hills Youth center permission to notify the non-custodial parent(s) of admission unless the treatment team determines that such notification would be detrimental to treatment. _____
Initial

_____ Name of Non-Custodial Parent(s)

_____ Phone Number of Non-Custodial Parent(s)

SIGN

_____ _____
Parent/Legal Guardian **Date**

_____ _____
Parent/Legal Guardian **Date**

_____ _____
Copper Hills Representative **Date/Time**

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COPPER HILLS YOUTH CENTER

CONSENT AND CONDITIONS FOR ADMISSION AND DISCHARGE

1. ADMISSION REQUEST:

I, _____ hereby consent to the admission of _____
Parent/Guardian Resident/Patient
at Copper Hills Youth Center for diagnosis and treatment services recommended by the attending physician.

2. EMERGENCY TREATMENT CONSENT:

a. It is understood that while at Copper Hills Youth Center the need for emergency treatment and/or transfer to other hospitals may become necessary and appropriate.
b. Should the need for such emergency treatment and/or transfer to another hospital be deemed necessary and appropriate by the attending physician, or the physician assigned by the facility, his assistants and designees, I consent to such emergency treatment and/or transfer to another hospital and to indemnify the facility, its staff, or any physician who may be in attendance, from loss resulting from such emergency treatment and/or transfer.

3. CONDITIONS FOR RESTRAINT AND SECLUSION:

a. It is understood and agreed that the use of reasonable restraint and/or conclusion may be necessary in order to protect a resident from harming himself/herself or others, or destroying property.
b. Should such restraint and/or seclusion become necessary during treatment, I understand and agree to indemnify the facility, its staff, or physician who may be in attendance, from any loss due to injury that may occur as a result of such restraint and/or seclusion.

4. CONDITIONS FOR SEARCH:

a. It is understood that upon admission the resident's person, clothing, and other belongings may be searched.
b. It is understood that items with potential for harm to the resident or others will be considered contraband and will be removed. Contraband items may be locked up for supervised use, sent home, or disallowed on the unit.
c. It is understood that any item given to a resident may be inspected for safety.
d. It is understood that every effort will be made by Copper Hills Youth Center staff to conduct searches in a manner that is respectful and sensitive to the resident's privacy.
e. Room searches will be done as needed to ensure unit and resident safety.

5. STILL PHOTOGRAPHY AND VIDEO RECORDING AUTHORIZATION:

a. It is understood the use of still photography is for the purpose of safety and identification purposes only.
b. It is understood the use of audio/visual equipment to record individual, group, and family therapy sessions are for internal staff training and therapeutic purposes only.

6. CONDITIONS REGARDING PERSONAL CLOTHING AND VALUABLE ITEMS AND FACILTIY PROPERTY:

a. To avoid loss or damage, residents are encouraged <u>not</u> to keep personal items of value on the unit. Items of value will be sent home.

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b. It is understood that money, jewelry, glasses, removable dental appliance, garments, and other items of value, **will not be replaced or reimbursed by Copper Hills Youth Center if loss or damage occurs**.
c. It is understood that the resident or parent/legal guardian will be responsible for any damage and/or destruction to facility property caused by the resident.

7. TEXTBOOKS:

It is understood that all textbooks lent to residents for use at Copper Hills Youth Center are the property of the facility and that the facility has the right to impose a penalty for missing, damaged, and defaced textbooks.

8. TEACHING INSTITUTION:

It is acknowledged that Copper Hills Youth Center will sometimes function as a clinical teaching site for various clinical professions. I understand that these clinicians in training may participate in various aspects of a resident's treatment under the supervision of a trained and licensed professional.

9. RELIGIOUS ACTIVITIES:

It is understood that non-denominational religious services are offered and made available on site to all residents, but the resident's participation is elective and on a voluntary basis. Residents may request a particular religious service and efforts will be made to accommodate the request.

10. GUARDIAN INFORAMTION:

Parents and residents will be given a copy of the resident/guardian handbook. The handbook will include a program description, Copper Hills Youth Center Statement of Resident's Rights and Responsibilities, Utah Statement of Resident's Rights and Responsibilities, and a formal complaint policy. It is understood that residents/guardians will abide by the rules, standard, agreements and policies of Copper Hills Youth Center.

I have read and understand the above conditions for admission. My questions and concerns have been addressed. I acknowledge that I am the resident and/or am duly authorized to execute these conditions for admission on the resident's behalf.

SIGN

Parent/Guardian	**Date**
Copper Hills Representative	**Date/Time**

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COPPER HILLS YOUTH CENTER

INFORMED CONSENT FOR PSYCHOTHERAPY

PURPOSE OF PSYCHOTHERAPY: Therapy is an integral part of a student's treatment while at Copper Hills Youth Center. Therapy is the interactive processes between a person or group and a qualified mental health professional. Therapy is designed to help alleviate specific problems causing distress and assist the student in understanding how their feelings and thoughts affect the ways they act, react, and relate to others. Its purpose is the exploration of thoughts, feelings and behavior for the purpose of problem solving or achieving higher levels of functioning.

GENERAL PROCEDURES USED IN THERAPY: Copper Hills Youth Center therapists are all masters level clinicians and are trained in various therapeutic models to help with the needs of Copper Hills Youth Center students. The two main treatment modalities used at CHYC are DDP (Dyadic Developmental Psychotherapy) and SPARCS (Structured Psychotherapy for Adolescents dealing with Chronic Stress). All therapists have had specific training in these two modalities. Therapists will each have their own therapeutic style and may use other modalities such as CBT (cognitive behavioral therapy), EMDR, DBT, etc.

LENGTH OF PSYCHOTHERAPY: Upon admission, each student is assigned a primary therapist. The student will meet with this therapist two hours per week, one hour for individual therapy and one for family therapy. Weekly family therapy can be done in person (if parents/guardians are local or visiting), via conference call or through video conference; days and times of family therapy will be determined by the therapist and the family. The student will participate in 2 psychotherapy groups weekly, which are also facilitated by a therapist (this may or may not be their individual therapist). The student will remain in therapy the duration of their stay at Copper Hills Youth Center and will terminate with their individual therapist upon discharge.

BENEFIT OF PSYCHOTHERAPY: Participating in therapy may result in a number of benefits to the student, including reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. However**,** such benefits may also require substantial effort on the part of the student, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

POTENTIAL RISKS OF PSYCHOTHERAPY: Therapy can be uncomfortable due to strong emotions that are accessed and released in session. This discomfort may include remembering and discussing unpleasant events, feelings and experiences. This may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, guilt, anger, frustration, loneliness, helplessness, etc. Students may experience a temporary worsening of their symptoms before improvement is noticed.

ALTERNATIVES TO PSYCHOTHERAPY: Residential treatment is a level of care that requires the student to have tried, unsuccessfully, a number of interventions prior to admission. Due to the student meeting criteria for this level of care, if the parent/guardian feels that this placement is not appropriate or is not meeting the needs of their student, the admissions department may be able to identify other residential facilities that could better meet the student's therapeutic needs.

PAYMENT FOR PSYCHOTHERAPY: The cost of therapy is included in the cost of treatment at Copper Hills Youth Center. No additional payment will be required.

CONFIDENTIALITY POLICY/LIMITATION: To ensure a positive therapeutic relationship your child's session information will be confidential.
Confidentiality **CANNOT** be maintained when:

- A student discloses a plan to cause serious harm or death to someone else who can be identified, and there is intent and/or ability to carry out this threat in the very near future.
- A student discloses a plan to cause serious harm or death to themselves, and with intent and/or ability to carry out this threat in the very near future.
- If a student is doing things that could cause serious harm to themselves or someone else, even if they do not intend to harm themselves or another person.
- A student discloses being abused-physically, sexually or emotionally-or that they have been abused in the past. In this situation, therapists are required, by law, to report the abuse to the Department of Child and Family Services.

Except for situations such as those mentioned above, the therapist may not tell the parent or guardian specific things the student shares during individual/group therapy sessions (clinical judgment will be used); they may be discussed in more general terms. However, the therapist may encourage the student to share these specific things during family therapy.
By signing below, you are stating that you have read and agree with the above information and are consenting for your student to participate in psychotherapy while at Copper Hills Youth Center.

_____ _____
Parent/Legal Guardian **Date**

_____ _____
Parent/Legal Guardian **Date**

_____ _____
Copper Hills Representative **Date/Time**

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PHILOSOPHY & PRACTICE FOR SECLUSION & RESTRAINT USE

WHAT IS THE PHILOSOPHY OF THE FACILITY REGARDING SECLUSION & RESTRAINT USE?

Copper Hills Youth Center promotes the use of non-physical interventions and seclusion/restraint is used as the last resort when the safety of the patient and/or others is compromised. The facility is committed to prevent, reduce and eliminate the use of seclusion/restraint through early identifications of high-risk behaviors or events. The dignity and privacy of patients will be preserved to the greatest extent during the implementation and monitoring of these interventions.

WHAT IS SECLUSION AND RESTRAINT AND WHEN ARE THEY USED?

Seclusion is any confinement of a single patient in a room or area where he/she is physically prevented from leaving or the perception is given to the patient that he/she is unable to leave the room.

Restraint is a physical hold to maintain safety that involuntarily restricts a patient's freedom of movement, activity or normal access to one's body. Medication is at times utilized to reduce severe anxiety/agitation as ordered by the physician on a one-time basis with guardian consent.

Seclusion or restraints are used when it has been determined that it will be the least restrictive intervention that will be effective to provide immediate physical safety of the patient, a staff member, or others and it is discontinued at the earliest possible time. They require a physician's order and are **never** used as a form of discipline, punishment or convenience for the staff.

WHAT ALTERNATIVES ARE TRIED BEFORE USING SECLUSION OR RESTRAINT?

❖ Staff use a variety of alternatives to try and avoid the use of seclusion/restraint. These options may include:

- Giving the patient clear instructions and directions about his/her behavior.
- Encouraging the patient to talk about what's making him/her angry and/or frustrated.
- Reducing negative stimuli in the patient's environment e.g. loud noises, turning out lights, allowing the patient alone time.
- Offering diversionary and physical activities e.g. TV, music, exercise, reading.
- Providing medications that the physician has ordered to help the patient to relax/gain control of his/her emotions.
- Using information provided by the patient and/or family regarding what calms him/her.

WHAT BEHAVIORS WILL RESULT IN RELEASE FROM RESTRAINT?

Patients are released from restraints when they demonstrate behavioral control, show improved ability to understand and follow directions and are no longer dangerous to themselves, other patients and/or staff.

HOW CAN YOU HELP?

If you are aware of events in the past that you think may trigger these behaviors, or if you are aware of methods that have been used in the past that were helpful, please inform the staff. To the extent that it is possible, we will incorporate this information into the treatment plan.

The parent/guardian will be notified when seclusion/restraint is used and the reason for this intervention in all cases with minors (patient younger than 18 years of age)

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

CHYC REPRESENTATIVE_____ **DATE/TIME** _____

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COPPER HILLS YOUTH CENTER

INDIVIDUAL EDUCATION PROGRAM (IEP):

Resident Name:	Date of Birth:	Admission Date:

Copper Hills Youth Center Educational Policy:

Copper Hills Youth Center strives to meet all IEP requirements for every student. In order to better serve and meet the needs of our students, we request that each school district or SELPA send the student's current IEP as part of the admission packet. Although we realize that this is not the final transfer IEP, it will give our education staff an opportunity to review the student's current IEP goals.

In addition, Copper Hills reserves the right to amend the transfer IEP at the 30 day review to insure that the student's IEP goals are appropriate for the services offered by our facility.

_____ _____

Parent/Guardian Date Copper Hills Representative Date/Time

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COPPER HILLS YOUTH CENTER

PLACEMENT DISRUPTION AGREEMENT

Resident Name:	Date of Birth:	Admission Date:

Copper Hills Youth Center PDA:

After careful review of the clinical information received for the resident listed above, we feel that they are appropriate at this time for admission into our treatment program. We currently have beds available and look forward to working with them.

If for any reason, the resident's placement at Copper Hills is disrupted and discharge is required, they will be transferred back to the sending state or the appropriate placement determined by their legal and clinical team.

For any questions and to arrange admission please contact Arva Loveland at (801) 304-7194. Please fax signed form to (801) 214-2931.

Parent/Guardian Date

Copper Hills Representative Date/Time

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COPPER HILLS YOUTH CENTER

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PERMISSION FOR RECREATION THERAPY ACTIVITIES

❖ **Adventure Recreation Outings:**

Over the course of treatment residents have the opportunity to attend adventure recreation outings with the Recreation Therapy Department. These outings include, indoor and outdoor rock climbing, canoeing, river rafting, hiking, snowshoeing, downhill skiing and cross-country skiing. To attend these outings, residents must be on phase Leader or Guide. In order to provide maximum safety and required gear, Copper Hills Youth Center provides the majority of these outings through SPLORE, a non-profit organization that provides recreation to people with disabilities and illness. All activities are beginner or intermediate as skills develop. To participate in each outing residents are required to submit a Participant Agreement, Release and Assumption of Risk. (See form on page 11). For more information please feel free to visit the SPLORE website: http://splore.org/

I provide permission for my child to attend these outings and to allow the Recreation Therapy Department to sign as guardian on the Participant Agreement, Release and Assumption of Risk form.

☐ Yes

☐ Yes except for the following: _____

☐ No

☐ **Consent** ☐ **Do NOT Consent** _____ **Initial**

❖ **Overnight Camping Trips:**

In conjunction with the summer adventure recreation outings, the residents have the opportunity to attend overnight camping trips with the Recreation Therapy Department. These trips do not exceed more than one night away from Copper Hills Youth Center and residents must be on phase Leader or Guide. To provide permission for your child to attend the overnight camping trips, please sign below. As your child is eligible to attend overnight camping trips, a Recreation Therapist will notify you 24 hours in advance prior to leaving for the outing in case you have any questions or concerns.

☐ **Consent** ☐ **Do NOT Consent** _____ **Initial**

❖ **Challenge Course Participation:**

Over the course of treatment residents will have the opportunity to participate in the Recreation Therapy Challenge Course Program. On a weekly basis eligible residents will be able to engage in a series of ground, low and high initiatives that build trust, support, teamwork, confidence and communication skills. The course is made up of various cables, poles, and ropes that range from one foot off of the ground to 35 feet in the air. All Challenge Course groups are facilitated by a Level 1 Ropes Course Certified Recreational Therapist. I provide permission for my child to participate in the Challenge Course Program over the course of treatment.

☐ **Consent** ☐ **Do NOT Consent** _____ **Initial**

_____ _____

Parent/Guardian Date Copper Hills Representative Date/Time

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COPPER HILLS YOUTH CENTER

PIVOT ADVENTURE COMPANY, LLC
ACKNOWLEDGMENT OF RISK, RELEASE OF LIABILITY, AND INDEMNITY AGREEMENT

READ CAREFULLY BEFORE SIGNING – THIS LIMITS PIVOT'S LIABILITY

I, _____, on behalf of myself and my child (collectively referred to as "I", "my", or "me") have voluntarily chosen to participate in recreational activities, including but not limited to indoor and outdoor rock climbing, ropes course activities, hiking, snowshoeing, mountain biking, cross-country and downhill skiing, snowboarding, and travel associated with these activities (collectively, "the Activities"). I understand that participation in the Activities poses inherent and other risks of INJURY and DEATH. The risks associated with the Activities include, but are not limited to, falling; landing on or striking padded or unpadded surfaces; being injured by falling objects or participants; being injured by the actions or inactions of other participants, including but not limited to other participants' failure to belay properly; movement of climbing holds; equipment failures of any kind; naturally occurring hazards and dangers of all kinds; steep and uneven terrain and trail conditions including snow (surface and subsurface conditions), ice, rocks, dirt, mud, sand, vegetation, and cliffs; hazards associated with changes in weather, temperature, and lighting conditions; and other rugged terrain conditions. The risks also include hazards and dangers associated with the use of manmade structures, vehicles, materials, and equipment, including misuse, defect, failure, or inadequacy of equipment. Other risks include those associated with the use of facilities, including indoor climbing facilities; ropes course facilities; ski resorts including chairlifts, surface lifts, and other conveyances; and participating in instruction and/or special events (collectively, "use of the facilities"). Despite these risks and all other risks, and TO THE FULLEST EXTENT ALLOWED BY LAW, I ACKNOWLEDGE AND AGREE TO EXPRESSLY ASSUME ALL RISKS OF INJURY OR DEATH that might be associated with or arise out of my participation in the activities or use of the facilities.

In consideration for being permitted to participate in the Activities and engage in use of the facilities, I AGREE TO RELEASE FROM ANY LEGAL LIABILITY AND AGREE NEVER TO SUE Pivot Adventure Company, LLC and all of its successors, heirs, assigns, directors, officers, partners, investors, shareholders, members, agents, employees, owners, volunteers, facility landowners, parent and subsidiary companies, and affiliated companies (collectively herein, "Pivot") for injury or death resulting from my participation in the Activities or use of the facilities, regardless of the cause, including the alleged NEGLIGENCE of Pivot. I further AGREE TO DEFEND, INDEMNIFY AND HOLD HARMLESS Pivot for any claims, lawsuits, damages, attorney fees, costs or judgments arising out of my participation in the Activities or use of the facilities.

I UNDERSTAND THIS IS A RELEASE OF LIABILITY that will apply whenever I or my child participate in the Activities or engage in use of the facilities with or associated with Pivot. I understand that this RELEASE OF LIABILITY will prevent me, my child, and our representatives and heirs from filing suit or making any claim for damages in the event of injury or death from my or my child's participation in the Activities or use of the facilities. Additionally, in the event I file or my child or any legal representative files a claim or a lawsuit arising out of my or my child's participation in the Activities or the use of the facilities, I AGREE TO DEFEND, INDEMNIFY AND HOLD HARMLESS Pivot for any damages, attorney's fees, or costs arising out of such a claim or a lawsuit. With a full understanding of this agreement, I enter into it freely and voluntarily and agree that it is binding upon me, my child, our heirs, assigns and legal representatives.

I understand that I alone am responsible to decide whether I and/or my child should engage in the Activities. I confirm that the participant is physically and mentally capable of participating in the Activities, and I understand that if my or my child's mental or physical condition changes after the execution of this agreement such that I, he or she is not capable of participating in the Activities, I am responsible to cease and/or have my child cease participating. I acknowledge that Pivot's representatives and/or other participants or spectators may photograph or videotape the Activities and facilities, including my or my child's participation therein. I agree that Pivot may use these recordings in any way, including but not limited to for marketing purposes and as evidence, without compensation or restriction. I understand and agree that this agreement is severable and that if any clause is found to be invalid, the balance of the contract will remain in effect and will be valid and enforceable.

Signature of Participant (if over 18):_____ Date _____

Prospective participants under the age of 18 years are required to have a parent or legal guardian read and sign.

Print Name of Participant _____ DOB: _____

Print Name of Parent/Legal Guardian _____ Relation _____

THIS IS A RELEASE OF LIABILITY – DO NOT SIGN UNLESS YOU AGREE TO BE BOUND BY ITS TERMS

Signature of Parent/Legal Guardian _____ Date _____

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SPLORE

PARTICIPANT AGREEMENT, RELEASE AND ASSUMPTION OF RISK

In consideration of the services of Splore, their agents, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as "Splore"), I hereby agree to release, indemnify, and discharge Splore, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I expressly acknowledge that participation in Splore outdoor activities such as rock climbing, river rafting, canoeing and cross country skiing entails known and unanticipated risks that could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity. The risks include, among other things: slipping and falling; falling objects; water hazards; exhaustion; exposure to temperature and weather extremes which could cause hypothermia, hyperthermia (heat related illnesses), heat exhaustion, sunburn, dehydration; exposure to potentially dangerous wild animals, insect bites, hazardous plant life; equipment malfunction or failure; accidental drowning; and improper lifting or carrying.
2. I expressly recognize and acknowledge and accept that Splore staff and volunteers have difficult jobs to perform during outdoor activities; that they seek safety, but they are not infallible; that they might be unaware of or misjudge a participant's fitness, awareness, weight or abilities; that they might misjudge the weather or other environmental conditions; and that they may give incomplete warnings or instructions; and the equipment being used might fail or malfunction.
3. I expressly agree and accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.
4. I hereby voluntarily release, forever discharge, and agree to indemnify and hold Splore harmless from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of Splore's equipment or facilities, including any such claims which allege negligent acts or omissions of Splore.
5. Should Splore or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.
6. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the costs of such injury or damage myself. I further certify that I am willing to assume the risk of any medical or physical conditions I may have.
7. In the event that I file a lawsuit against Splore, I agree to do so solely in the state of Utah, and I further agree that the substantive law of Utah shall apply in that action without regard to the conflict of law rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against Splore on the basis of any claim from which I have released them herein.

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be found by its terms.

Signature of Participant _____ Print Name _____
Address _____ City State Zip _____
Phone _____ Date _____

PARENT'S OR GUARDIAN'S ADDITIONAL INDEMNIFICATION
(Must be completed for participants under the age of 18)
In consideration of _____ (print minor's name) ("Minor) being permitted by Splore to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold Splore harmless from any and all claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor, specifically including but not limited to any claims associated with youth participation in rafting trips. I have been informed of the risks associated with youth participation in Splore activities and recognize them and acknowledge them and hereby knowingly accept them.

Signature of Parent or Guardian: _____ Print Name: _____

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COPPER HILLS YOUTH CENTER

RESIDENT GRIEVANCE PROCESS AND RESIDENT RIGHTS

Resident Name:	Date of Birth:	Admission Date:

Resident Grievances and Rights:

During your residents stay here you and your resident have the rights listed in the Patient/Parent Handbook. The grievance process at Copper Hills Youth Center is explained to your resident upon admission during their incoming physical with the nurse. They will sign the rights page and the rights are posted on the unit. There are grievance forms posted throughout the building and Resident Rights will be posted on the units. Residents can fill out a grievance form and put it in the locked black boxes located on the units if they feel that there has been a grievance that needs to be addressed.

If you have questions or needs related to your resident's rights you can contact the resident advocates at: (800-776-7116 for Copper Hills Youth Center).

Dave Anderton at: (801) 304-7150

Joint Commission at: (800) 994-6610
E-mail: complaint@jointcommission.org

Utah State at: Division of Substance Abuse and Mental Health at (801) 538-3939

_____ _____

Parent/Guardian Date Copper Hills Representative Date/Time

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COPPER HILLS YOUTH CENTER

FINANCIAL AGREEMENT
Parents

Resident Name:	Date of Birth:	Admission Date:

Authorization to Pay Insurance Benefits and Financial Agreement:

As an inducement to obtain professional services and goods, I hereby assign to Copper Hills Youth Center all medical and/or surgical benefits payable to me from group or individual health insurance policy. I authorize and direct that all payments be made directly to Copper Hills Youth Center and/or its professional staff with the understanding that charges will not exceed regular charges for treatment or professional services. I agree to pay all charges which are not covered or paid by the insurance company or my third-party sponsor.

As an inducement to obtain professional services and goods, I agree to pay the charges of Copper Hills Youth Center and/or its professional staff, not to exceed regular charges for treatment and professional services. I further agree to pay all costs and expenses rendered by other healthcare providers in connection with the treatment as ordered by the attending physician, i.e. medical consultations, dental services, optical services, or other related medical treatment. Payment is due thirty (30) days after billing date. The unpaid balance shall bear interest at the rate of 18% per annum, thirty (30) days after the billing date. I agree to pay reasonable attorney's fees and collection fees of up to 50% in the event my unpaid charges are referred for collection. I irrevocably submit to personal jurisdiction in the State of Utah and agree that all legal action relating to this agreement shall be initiated in the Third Judicial Court, Salt Lake County, State of Utah.

_____ _____

Parent/Guardian Date Copper Hills Representative Date/Time

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COPPER HILLS YOUTH CENTER

FINANCIAL AGREEMENT
Caseworker/State Representative

Resident Name:	Date of Birth:	Admission Date:

Authorization to Pay Insurance Benefits and Financial Agreement:

As an inducement to obtain professional services and goods, The State/Division Agency hereby assign to Copper Hills Youth Center all medical and/or surgical benefits payable to The State/ Division from group/or individual health insurance policy and authorize and direct that all payments be made directly to Copper Hills Youth Center for professional services rendered or goods supplied by Copper Hills Youth Center and/or its professional staff with the understanding that charges will not exceed regular charges for treatment or professional services. As a Representative of The State/ Division, The State/ Division agrees to pay all charges which are not covered or paid by the insurance company or the third-party sponsor.

As an inducement to obtain professional services and goods, The State/ Division agrees to pay the charges of Copper Hills Youth Center and/or its professional staff, not to exceed regular charges for treatment and professional services. The State/ Division will further agree to pay all costs and expenses rendered by other healthcare providers in connection with the treatment as ordered by the attending physician, i.e. medical consultations, dental services, optical services, or other related medical treatment. Payment is due thirty (30) days after the billing date. The unpaid balance shall bear interest at the rate of 18% per annum, thirty (30) days after the billing date. The Sate/ Division shall agree to pay reasonable attorney's fees and costs in the event the unpaid charges are referred for collection. The state/ Division irrevocably submit to personal jurisdiction in the State of Utah and agree that all legal action relation to this agreement shall be initiated in the Third Judicial Court, Salt Lake County, State if Utah.

Caseworker/State Representative Date

Copper Hills Representative Date/Time

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ADMITTING MEDICATION RECONCILIATION/ORDERS

Resident Name:	Date of Birth:	Admission Date:

Allergies:

- ☐ Resident is currently NOT taking or prescribed ANY medications.
- ☐ Resident is taking the following medications as listed below (include prescribed, over the counter, supplements, and herbal medications). **Please fill out completely**.

Parent/Guardian: Please fill out this section and authorize medication to be continued upon admission						Facility Use Only
Medication Name	**Medication Dose**	**Medication Route**	**Medication Frequency**	**Reason for taking the medication**	**Guardian authorization to continue medication**	**Physician order to continue medication upon admission**
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

The purpose, risks, and side effects of these medications have been discussed with me by the previous prescribing physician(s). I wish for the medication(s) to be continued. I understand that my child is not compelled to take the medication(s) and that I may decide to stop my child's medication(s) at any time by notifying my child's attending psychiatrist.

I authorize my child's attending psychiatrist to verify foregoing medications with the previous prescribing physician(s) and I understand that my child's attending psychiatrist may recommend changes to the medication(s) based upon my child's symptoms and response to treatment.

During and emergency situation if the treatment is pursuant to or documented contemporaneously by written order the physician; the child may receive treatment or medication in the absence of their expressed and informed consent. Psychotropic medication will be administered to residents who refuse the medication only when it is considered a necessary part of the resident's treatment plan and only when the resident's interest in refusing medication is outweighed by behaviors deemed as imminent danger to self or others.

With these understandings, I authorize my child's attending psychiatrist or his/her designee to administer these medication(s) to my child at such interval as he/she deems advisable.

SIGN

Parent/Guardian and Relationship Date

Copper Hills Representative Date/Time

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COPPER HILLS YOUTH CENTER

IMMUNIZATION RECORD STATUS AND CONSENT FORM

Pursuant to licensure and accreditation requirements, Copper Hills Youth Center is charged with the obligation to maintain an infection control program, of which the immunization of residents is a vital part. As the parent/guardian of _____ (resident), you are responsible for providing documentary proof of immunizations. Complete immunization records must be submitted to Copper Hills Youth Center **at the time of admission**. If eligible, immunizations that are deficient will be administered by Copper Hills Youth Center, through the Vaccines for Children Program (VFC), at no cost to you. Residents must meet specific criteria to qualify for VFC.

Below you will find a list of the optional immunizations that if eligible for VFC our facility can administer to this resident. Please check the appropriate box indicating your consent or declination of each available inoculation.

Meningococcal Vaccine	☐ **Yes**, if eligible I would like my resident to receive the Meningococcal vaccine. ☐ **No**, I would not like my resident to receive the Meningococcal vaccine.
HPV Vaccine series	☐ **Yes**, if eligible I would like my resident to receive the HPV vaccine series. ☐ **No**, I would not like my resident to receive the HPV vaccine series.
Influenza Vaccine * ***Available October thru March***	☐ **Yes**, if eligible I would like my resident to receive the Influenza vaccine. *My child **DOES NOT** have any of the conditions listed below:* *- Serious allergy to eggs* *- Serious reaction to previous flu vaccine* *- History of Guillain-Barre syndrome* *- Adverse reaction to Thimerosal (a preservative)* *Guardian Initial: _____* ☐ **No**, I would not like my resident to receive the Influenza vaccine.

If you have any questions or need further information please feel free to contact our Infection Control Nurse at 801-304-7116.

_____ _____

Parent/Guardian Date Copper Hills Representative Date/Time

Facility use only: _____ ____

Signature: Received & Reviewed by Copper Hills Representative _____VFC Eligible _____Not VFC Eligible

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COPPER HILLS YOUTH CENTER

Over the Counter Medication Consent

Resident Name:	Date of Birth:	Admission Date:

Allergies:

- ☐ Tylenol
- ☐ Ibuprofen
- ☐ Maalox
- ☐ Tums
- ☐ Colace
- ☐ Milk of Magnesium
- ☐ Cepacol Throat Lozenge
- ☐ Delsym Cough Suppressant
- ☐ Mucinex Decongestant
- ☐ Miralax
- ☐ Supplements (multi-vitamins, vitamins B, C, D, folic acid, iron, and fish oil)
- ☐ Melatonin (over the counter supplements used as a sleep aid)
- ☐ Nasal Sprays (Flonase, saline)

I authorized my resident to be prescribed the above medications and monitored by Copper Hills Youth Center medical and nursing staff. I understand the use of these medications is for my resident comfort and will only be given after being assessed for need by Copper Hills Youth Center medical staff. I also understand the physician may not prescribe all of the medication listed above due to potential interactions with medications my resident may be prescribed. Copper Hills Youth Center believes in using alternative therapies like, but not limited to mindfulness, deep breathing, physical exercise, and heat and cold compresses for resident comfort needs.

Parent/Guardian Date Copper Hills Representative Date/Time

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RESIDENT INITIAL CONTACT INCLUSION LIST

Resident Name:	Unit:	Admit Date:	Security Code #

TELEPHONE CALLS: While at CHYC, residents have the right to make and receive telephone calls. The facility may not restrict these rights unless it is documented that such phone calls will impair treatment processes for the resident. In the event that phone conversations are impairing treatment, the resident's therapist and physician will evaluate the situation and may place restrictions on resident's right to receive and make phone calls. This decision will be evaluated every seven days. Residents will be allowed to send and receive phone calls to those indicated on the inclusion list below.

MAIL: It is a state regulation that mail remains private and not be read by staff, however, residents may be asked to read questionable correspondence aloud during individual therapy. Mail will be opened in the presence of the resident's therapist to ensure it does not contain dangerous or forbidden items. Residents will be allowed to send and receive mail to those indicated on the inclusion list below.

VISITORS: Residents have the right to receive visits from family members and extended family members only. The facility may not restrict these rights unless it is documented that such visitations are impairing treatment for the resident. In the event that visitations are impairing the treatment process, the resident's therapist and physician will evaluate the situation and may place restrictions on visitation. Restrictions will be evaluated every seven days. Residents will be allowed to receive visitation only from family and extended family members indicated on the inclusion list below.

As the parent/guardian of the resident, you have important information about the resident's friends and acquaintances. If you identify a person with whom the resident has a positive relationship with and would benefit the therapeutic process, please discuss adding this person to the inclusion list with the assigned therapist. Contact with friends is discouraged during the initial phases of treatment.

****PARENTS/GUARDIANS MUST INCLUDE THEMSELVES ON THIS LIST****

Date Added	Name	Relationship	Phone Number(s)	Phone X	Mail X	Visitor X	Date Deleted	Therapist Initials

Parent/Guardian Date

Copper Hills Representative Date/Time

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REQUEST FOR STUDENT RECORDS

Student Name _____ DOB_____
(Last, First, Middle)

Last School Attended: _____ Last Grade Completed_____

Address of School: _____
(Street, City, State, Zip)

School Phone _____ School Fax _____

Please send a COMPLETE TRANSCRIPT along with the student's record. In addition please include <u>ALL</u> of the following information:

- **Current IEP (Include name of tests given and results)**
- **Behavioral Intervention Plan (if needed)**
- **Functional Behavioral Assessment**
- **All forms pertaining to Special Education**
- **Discipline Records**
- **Credits earned to date (explanation if necessary)**
- **Copy of <u>IMMUNIZATION RECORDS</u>**

FERPA allows schools to disclose the above records, **without consent**, to the following parties or under the following conditions (34 CFR **§** 99.31):

- School officials with legitimate educational interest;
- Other schools to which a student is transferring

_____ _____
Registrar Date

Please fax Student Records <u>ONLY</u> to: 801-561-3393

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AUTHORIZATION FOR EXCHANGE/RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

Parent/Legal Guardian: _____ Relationship: _____

Pursuant to Federal Guidelines concerning confidentiality I, the undersigned parent/guardian of the above minor, authorize Copper Hills Youth Center, 5899 West Rivendell Drive, West Jordan, Utah 84088 (801) 561-3377 to release and/or exchange written and/or verbal information with:

Name of Organization Address Phone Number

_____

_____

_____

_____

I, the undersigned, consent to the release of information or documents pertinent to educational programming, psychiatric and medical treatment, substance abuse, and financial and insurance coverage/reimbursement. This information may include personal and family information regarding present or past problems (including drug and alcohol use) that have been identified as issues to treatment/follow-up/aftercare. The specific purpose(s) of the disclosure is _____.

I understand that the information being disclosed may not be protected from re-disclosure by the recipient of the information unless otherwise prohibited by state or federal law.

I understand that if the specific health information that is the subject of this Authorization contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol or drug abuse, psychological or psychiatric conditions, or genetic testing, the disclosure I am hereby authorizing will include that information.

I consent to the release/exchange of information or treatment records as follows:

- ☐ Verbal and Written Health Information Records, Specifically:
  - ___ Psychiatric Assessment ___ History & Physical Exam ___ Psychosocial History
  - ___ Treatment Plans ___ Nursing Assessment ___ Psychological Evaluation
  - ___ Discharge Summary ___ Other_____
- ☐ Verbal Exchange Only

I authorize the release of such information by mail, facsimile, telephone or personal contact.

I understand that I may revoke this consent at any time by written notification to the Director of Health Information management and/or the Hospital Administrator of the facility/faculties named above. I also understand that any release of information which has been made prior to my revocation and which was made in reliance upon this Authorization shall not constitute a breach of confidentiality. Unless I revoke this authorization prior to its expiration, this authorization to release information shall automatically expire 60 days from the date of execution, at which time no expressed revocation shall be needed to terminate my consent.

_____ _____

Resident Date Witness Date

_____ _____

Parent/Guardian Date Copper Hills Representative Date/Time

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INSURANCE DOCUMENTATION

Resident Name:	Date of Birth:	Admission Date:

Private/Commercial Insurance

	Insurance Company	Policy Number	Policy Holder	Phone Number
Medical				
Dental				
Vision				

Policy Holder Information:
Name:_____
Social security Number:_____
Date of Birth:_____

Any balance not covered or unpaid by the insurance company will be the responsibility of the custodian/guardian.

_____ _____
Guardian Signature Date

State Custody and/or Medicaid Insurance

	Insurance Company	Policy Number	Policy Holder	Phone Number
Medical				
Dental				
Vision				

Case worker/ Custodian:
Name:_____
Phone Number:_____
Address:_____
_____

*****For billing purposes a copy of the insurance card(s) is required at admission*****

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COPPER HILLS YOUTH CENTER

RESIDENT INVENTORY

Resident Name: _____ Unit: _____

Item	Brand	Number	Exit Inventory

_____ _____

Guardian Signature Date

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TELEHEALTH INFORMED CONSENT FORM

PATIENT INFORMATION
Patient Name: _____ Date of Birth: _____ Site Where Patient is Seen via Telehealth: _____ Consulting Provider Name Seeing Patient via Telehealth: _____ Provider Location: _____

INTRODUCTION

During your stay here at Copper Hills Youth Center, it is possible that you will have a clinical visit using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. The information may be used for diagnosis, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemedicine staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconferencing technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to insure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks:

There are potential risks associated with the use of telehealth which include, but may not be limited to:

- A provider may determine that the telehealth encounter is not yielding sufficient information to make an appropriate clinical decision.
- Technology problems may delay medical evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this Form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I also understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telehealth:

I have read and understand the information provided above regarding telehealth, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

I hereby authorize _____ to use telehealth in the course of my diagnosis and treatment.
(Agency or Physician Name)

Signature of Guardian/Authorized Signer_____ Date_____

If Authorized Signer, relationship to patient _____

CHYC Representative _____ Date/Time _____

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COPPER HILLS YOUTH CENTER

Things for Boys to Bring

Clothing:

- Underwear – a minimum of seven (7)
- Ankle Socks – a minimum of seven (7)
- Jeans/shorts that fit without the need for a belt
- Pajamas
- T-shirts
- Athletic/sport shoes*
- Slippers
- Swim trunks without a drawstring (modest)
- Coat without hood (from October to March)
- Gloves (from October to March)
- Winter boots without laces (from October to March)
- Light jacket without a hood
- Sweatshirt (without hood)
- Sweatpants (without drawstrings)

Other:

- Pillow (optional)
- Blanket (optional)
- Comforter (optional)
- Personal necessities (soap, shampoo, conditioner, toothpaste, toothbrush, deodorant, hair brush)
- Electric shaver (optional)
- Small stuffed animals (2 maximum)
- Residents may want to bring money to place in their personal account. We recommend $10-$50. (optional)

*Velcro zip-ties will be provided to replace shoelaces

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Things for Boys NOT to Bring

All clothing must fit comfortably. All inappropriate clothing and items will be returned to parents or kept until resident is discharged. All clothing is subject to approval by the Director.

Clothing:

- Sweatshirt/Jacket with a hood
- Tight clothes
- Baggy clothes
- Gang related clothing
- Combat boots
- Frayed or torn clothing
- T-shirts with occult/concert themes
- Tank top undershirts
- Shoe laces (Velcro zip-ties will be provided for shoes that need laces)
- Scarves
- Belts
- Any clothing with a drawstring or tie (to include sweatshirts with a drawstring in the hood)

Other:

- Personal Electronics (cell phones, mp3 players, CDs, DVDs, etc.)*
- Aerosol hair sprays or other aerosol products
- Hair dyes/colored hair gel/mousse
- Products with alcohol
- Glass (including picture frames etc.)
- Razors/sharp objects
- Drugs, cigarettes or alcohol
- Expensive or sentimental items or jewelry (no necklaces)
- Mirrors
- Food

* The unit has a stereo, mp3 players and video games for the residents to use.

5899 West Rivendell Drive, West Jordan, UT 84081 • (801) 561-3377 *phone* • (801) 214-2931 *fax*

COPPER HILLS YOUTH CENTER

Things for Girls to Bring

Clothing:

- Jeans and shorts that fit without the need for a belt
- Underwear – a minimum of seven (7) (no thongs)
- Ankle Socks – a minimum of seven (7)
- Bras (no underwire)
- Sport bras
- T-shirts
- Athletic/sport shoes*
- Slippers
- One piece bathing suit (modest) and swim shorts (optional)
- Coat without a hood (October – March)
- Gloves (October – March)
- Winter boots without laces (October – March)
- Light jacket without a hood
- Sweatshirt without a hood
- Sweatpants without drawstrings
- Dresses or skirt outfits 2" above the knee or longer (conservative) (optional)

Other:

- Pillow (optional)
- Blanket (optional)
- Comforter (optional)
- Personal necessities (soap, shampoo, conditioner, toothpaste, toothbrush, deodorant, hair brush)
- Electric shaver (optional)
- Small stuffed animals (2 maximum)
- Residents may want to bring money to place in their personal accounts. We recommend $10-$50. (optional)

*Velcro zip-ties will be provided to replace shoelaces

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COPPER HILLS YOUTH CENTER

Things for Girls NOT to Bring

All clothing must fit comfortably. All inappropriate clothing and items will be returned to parents or kept until resident is discharged. All clothing is subject to approval by the Director.

Clothing:

- Sweatshirt/Jacket with a hood
- Tight clothes
- Baggy clothes
- Sleeveless/off the shoulder tops
- Gang related clothing
- Combat boots
- Bikinis
- Thong underwear
- Earrings
- Frayed or torn clothing
- Half shirts/midriff
- T-shirts with occult/concert themes
- Shoe laces (Velcro zip-ties will be provided for shoes that need laces)
- Scarves
- Belts
- Any clothing with a drawstring or tie (to include sweatshirts with a drawstring in the hood)

Other:

- Personal Electronics (cell phones, mp3 players, CDs, DVDs, etc.)*
- Aerosol hair sprays or other aerosol products
- Hair dyes/colored hair gel/mousse
- Products with alcohol
- Nail polish remover
- Glass (including picture frames, etc.)
- Black or dark make-up
- Razors/sharp objects
- Drugs, cigarettes or alcohol
- Expensive or sentimental items or jewelry (no necklaces)
- Mirrors
- Food

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