



8706 S 700 E, SUITE 205 - Sandy, UT 84070 – 801-277-7591

INTAKE AND ADMISSIONS

Note: All questions contained in this questionnaire are optional and will be kept strictly confidential

Personal Information	
Client	Responsible Party (if different from client)
Full Name:	Full Name:
Date of Birth:	Date of Birth:
Gender:	Gender:
Race:	Race:
SSN:	SSN:
Driver's License #:	Driver's License #:
Marital Status:	Marital Status:

Contact Information	
Client	EMERGENCY CONTACT
Cell:	Name:
Home:	Relationship:
Work:	Phone:
Email:	Email:
Address:	Address:
Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No

Current psychiatrist: Yes No If yes, name/phone:

What is your motivation for seeking treatment with Pathways?

What are your treatment goals?



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PERSONAL MEDICAL HISTORY

Allergies: _____

Client Height: _____ Client Weight: _____

Any significant childhood illnesses/problems:

Any medical problems that other doctors have diagnosed:

- 1.
- 2.
- 3.
- 4.

Surgeries:

Year	Reason	Hospital

Other Medical or Psychiatric Hospitalizations:

Year	Reason	Hospital

Any Psychiatric or Substance Abuse Outpatient Treatment:

Year	Reason	Hospital/Program

List your prescribed and over-the-counter drugs, such as vitamins and inhalers:



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Drug	Dosage	Frequency Taken

Allergies to Medications:

Drug	Type of Reaction

Please check if you have, or have had any symptoms or problems in the following areas to a **significant** degree and briefly explain:

<input type="checkbox"/> Cold/Flu	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Bladder/Prostate	<input type="checkbox"/> Anxiety/PTSD
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> Skin/Herpes	<input type="checkbox"/> Immune System	<input type="checkbox"/> Infections	<input type="checkbox"/> Headaches/Migraine
<input type="checkbox"/> Depression	<input type="checkbox"/> Cancer	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cushing's Syndrome
<input type="checkbox"/> Anti-Depressants	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Ears	<input type="checkbox"/> Sexual Disorders
<input type="checkbox"/> Stimulants	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Intestinal/Bowel	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Autism	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stress	<input type="checkbox"/> Energy Level
<input type="checkbox"/> Heroin	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Weight
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Other pain/discomfort
<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Hormone Imbalance

Explain if necessary:



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FAMILY HISTORY

Family Member	Name	Age	Sex (M or F)	Significant Health Problems
Father			M	
Mother			F	
Siblings:				
Grandmother (Mom's Side)			F	
Grandfather (Mom's Side)			M	
Grandmother (Dad's Side)			F	
Grandfather (Dad's Side)			M	



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CONSENT FOR TREATMENT

I acknowledge that I have received, have read (or have had read to me), and now understand the information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the recovery oriented system of care provided by this agency, its' contractors, and/or its' employees. I understand that developing a treatment plan and regularly reviewing the work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of medical treatment, behavioral health, counseling, recovery coaching, case management, supportive services, mentoring or of any other procedures provided by this agency, its' contractors or employees.

I am aware that I may stop any course of treatment this agency is providing at any time. The only thing I will still be responsible for is paying for the services I have already received, any outstanding co-payments, or for missed appointments that I have not cancelled within 24 (twenty four) hours in advance.

I know that I must call to cancel an appointment at least 24 (twenty four) hours before the time of the appointment. If I do not cancel or do not show up within the allotted time, I will be charged a no show fee of \$50. I also know that I will have to pay for missed sessions incurred before I have made arrangements to cancel.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), costs, date(s), and providers of any services, psycho-education, recovery coaching or medical treatments that I receive if I am submitting services for insurance payment. ***I understand that I will be responsible for the cost of all services provided if the insurance denies my claims or coverage for the services at PATHWAYS.*** I understand that if payment for services I receive is not made, the therapist or other medical providers may stop my treatment. I understand that if my account becomes delinquent it will be sent to a collection agency. I will be responsible for the collection agency fees.

My signature below shows that I understand and agree with all of these statements.

Client Signature (or person acting for Client)

Date

Printed name

Relationship (if not Client)



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TRANSPORTATION LIABILITY RELEASE FORM

In consideration for being a passenger in a PATHWAYS Employee’s personal vehicle or another vehicle that is driven by a PATHWAYS Employee, I hereby RELEASE, WAIVE, DISCHARGE and will not sue PATHWAYS dba Pathways Real Life Recovery in the State of Utah.

To the best of my knowledge, I am fully aware of the risks and hazards associated with vehicular travel. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained by me, or any loss or damage to personal property owned by me, as a result of being a passenger in these vehicles, WHETHER CAUSE BY NEGLIGENCE OR ACCIDENT or otherwise.

I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS THE LEASES from any loss, liability, damage or costs, including court costs and attorneys’ fees that may incur WHILE BEING A PASSENGER IN SAID VEHICLE, WHETHER CAUSE BY NEGLIGENCE OR ACCIDENT or otherwise.

It is my express intent that this release and hold harmless agreement shall bind the members of my family and spouse (if any), if I am alive, and my heirs, assigns, and personal representatives, if I am not alive, and shall be deemed as a RELEASE, WAIVER, DISCHARGE, AND COVENEANT NOT TO SUE the above named RELEASEES. I hereby further agree that this waiver of liability and hold harmless agreement shall not be constructed in accordance with the laws of the State of Utah.

I UNDERSTAND THAT THE OWNER OR OWNER’S INSURANCE WILL NOT BE RESPONSIBLE FOR ANY MEDICAL COSTS ASSOCIATED WITH AN INJURY I MAY SUSTAIN WHILE BEING A PASSENGER IN SAID VEHICLE. Any such coverage is at the benevolence and sole discretion of PATHWAYS.

IN SIGNING THIS REALEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the above waiver of liability and hold harmless agreement, understand it, and sign it voluntarily as my own free act and deed; no oral representations, statements or inducements, apart from the aforementioned written agreement, have been made. I am at least 18 (eighteen) years of age and fully competent and I execute this release for full, adequate, and complete consideration fully intending to be bound by same.

Client Signature

Client Printed Name

Date



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CLIENT/CONSUMER RIGHTS

As a client of Pathways, you have the right to:

-Privacy of information, your clinical records will not be released without a signed release of information designating where the information should be sent.

-If your treatment is involuntarily terminated, you have the right to appeal this decision and a meeting will be scheduled with the clinical director to discuss your reinstatement. The possible reasons for involuntary termination of care includes, but is not limited to: probation/parole violations, assaulting another client/consumer or therapist, missing two appointments without notice.

-Freedom from potential harm or acts of violence from other clients/consumers and staff.

-Know the cost of your therapy sessions. If this has not been addressed prior to your intake packet completion, please ask for a copy of our financial agreement.

-File a complaint or grievance about your therapist with the program director or CEO of the company, or file a grievance with the state licensing board.

-Freedom from discrimination.

-Be treated with dignity and respect.

-Smoke outside the facility, at least 25 feet away from the entryway of Pathways.

-If you are court ordered into Pathways, we have a responsibility to the court. Non-compliance or failure to follow through with court orders will be reported to the court.

I have read the above rights and understand what my rights are as a client/consumer of Pathways. If I had any questions about my rights, they were clearly explained to me.

Signature

Date

Witness/Staff

Date



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HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration



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requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

Other Permitted and Required Uses and Disclosures: will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization: at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS:

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.



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You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached. You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Client Date

Parent/Guardian of Minor Date



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PATHWAYS MANDATORY PARTICIPATION

As a client participating with Pathways, you will be required to do the following:

1. Attend required groups, as outlined by your therapist and schedule.
2. Agree to drug/alcohol testing UA's, as outlined by your therapist (adults)
3. Adolescents (under 18 years of age) are **required** to take 2 drug/alcohol testing UA's weekly.

I acknowledge and agree to these terms of service with Pathways Real Life Recovery.

Client

Date

Parent/Guardian of Minor

Date



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FINANCIAL CONTRACT AGREEMENT FORM

This financial agreement is between the Client and/or the responsible party for payment for all services rendered. I completely understand and agree that I the Client, or responsible party, has **full responsibility** to pay Pathways, and therefore guarantee full payment for all charges. In the event that Client is a minor or is subject to legal guardianship, the parent/legal guardian of Client will hereinafter be referred to as “Client”.

1. FINANCIAL INFORMATION: The Responsible Party will provide financial information regarding ability to pay for treatment services and/or room and board.
2. THIRD PARTY PAYER: PATHWAYS will make every reasonable effort to bill any appropriate and pre-arranged third party payers, such as government entities or insurance providers. In the case of clients covered by private medical insurance carriers, PATHWAYS requires the Responsible Party to render payment to PATHWAYS for services provided and to file any claims for reimbursement with their medical insurance carrier. **Responsible Party understands it will be responsible for the portion of fees not covered or paid by the insurance company. This includes any deductibles, co-payments, or charges for services deemed unallowable by the insurance carrier.** Responsible Party understands it must provide correct and complete insurance information upon admissions to PATHWAYS. Responsible Party agrees that, until the necessary information is provided, and, where the Client is covered by private medical insurance, until reimbursement is received from such insurer, Responsible Party is responsible for payment of any services provided by PATHWAYS. Responsible Party also understands that it is ultimately responsible to obtain any pre-authorization that may be required by any relevant insurance company/third party payer. Additionally, an insurance policy is a contract between the insured and the insurance company. PATHWAYS is not a party to that contract. Furthermore, the contract for services provided by PATHWAYS is between the Client/Responsible Party and PATHWAYS. PATHWAYS is, therefore, not under any obligation to attempt collection from the insurance carrier before collecting from Responsible Party. If the insurance company has not paid the account in full within 45 days, the balance due will be transferred to the Responsible Party's account and that party will be notified of such transfer. This amount will be due and payable in full at the time of the transfer. **NOTE: Please be aware that insurance plans vary as to the nature and extent of covered services. Therefore, some, and perhaps all, of the services provided by PATHWAYS may be non-covered services under the responsible party's third party payer's plan. Responsible Party understands it is solely responsible for determining whether coverage is available.**
3. RELEASE OF INFORMATION: I give consent to PATHWAYS to share all or any part of my personal medical information with any and all respective third party payers for the purposes of treatment, billing, and securing funding and/or any utilization review or audit conducted by agents of the third party payer.
4. PROMISE TO PAY: Responsible Party understands that by signing below, it is promising to pay all charges and reimbursements, including co-pays, accrued to PATHWAYS on Client's behalf.



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Responsible Party understands the minimum payment stated shall continue to be due and payable at the beginning of each month until all amounts accrued for services performed by Contractor under this agreement shall be paid in full. Payment of the charges and fees is considered part of the treatment process. Responsible Party understands that any payments made *will not be refunded* under any circumstances. Responsible Party and Client agree services may be terminated immediately at any time the account is 60 days in arrears. Responsible Party further agrees to satisfactorily make arrangements with the PATHWAYS of Utah accounting office to make payments, etc. if the account should become delinquent.

5. DELINQUENCY, APPEAL, AND COLLECTION: In the event the account becomes delinquent (as defined in the preceding paragraph), Responsible Party has 60 days to notify the PATHWAYS of Utah accounting office of any desire to appeal for reduction in co-pays, charges, etc. If Responsible Party does not follow the above procedures or respond after good faith attempts by PATHWAYS of Utah to contact Responsible Party, the account may be turned over to an attorney or collection agency for collection. In the event the account is turned over to collection, Responsible Party shall be liable for reasonable collection costs, including attorneys' fees, whether or not litigation is commenced. PATHWAYS reserves the right to modify collection efforts and time schedules for any account deemed, in its judgement, to warrant such treatment. Delinquent accounts shall bear interest at the rate of twenty one percent (%21) per annum.
6. Such adjustments may include, but are not limited to placing accounts with attorneys or collection agencies, or pursuit of other methods of legal recourse to insure collection of accounts. Any lawsuit arising from or relating to this Agreement shall be commenced exclusively in the state or federal courts situated in the State of Utah, and the parties hereto irrevocably consent to the jurisdiction of such courts. This Agreement shall be governed by and construed in accordance with Utah law.
7. CO-PAYMENTS: If Client is admitted with funding assistance from a third party payer, Responsible Party understands it may be required to make a co-payment for treatment services rendered. The amount of the co-payment is based on those established by the relevant insurance company. If you are unsure as to the amount of your possible co-pay amount, please seek that information from the PATHWAYS of Utah accounting office.
8. FEE SCHEDULE AND RATES: Below are the published rates. Responsible Party understands it will be required to pay the published rates for treatment services rendered **unless otherwise agreed upon.**



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CASH PAY FEE SCHEDULE

*Pathways Admission Fee (all clients)	\$1000 (one-time fee, non-refundable)
Day Treatment Program (PHP)	\$24,500 per 100 hours
Intensive Outpatient (IOP)	\$24,500 per 100 hours
Outpatient Therapy	\$195 per hour
Transitional Living Program	\$1,750 per month
Sober Companion	\$1000 per day/ \$500 half day

INSURANCE

For clients utilizing insurance benefits, we will bill the following amounts. (This is not a complete list.) Any amount due from the client will be discussed at time of admission, as these amounts vary, and are listed below. Any questions please ask admission staff.

Service	Amount Billed to Insurance
*Pathways Admission Fee (all clients)	\$1000 (one-time fee, non-refundable)
Initial Eval	\$500.00
PHP/ Day Tx Substance abuse	\$1,600.00
PHP/ Day Tx Mental Health	\$1,600.00
Intensive Outpt SA	\$1,100.00
Intensive Outpt MH	\$1,100.00
Therapy session 30 min	\$300.00
Therapy session 45 min	\$400.00
Therapy session 60 min	\$500.00

I agree to the following payment fee schedule (if applicable)

- Client Responsibility for 2021: _____ (plus insurance)
 Amount: _____ Date: _____
 Amount: _____ Date: _____
- Amount: _____ per month until balance paid in full.

****Admission fee covers all admin costs required before treatment can begin including arranging schedules, insurance authorizations, and initial paperwork. This fee is non-refundable.***

Payments not made for the above dates/schedules may result in a \$25.00 late fee and a 21% interest rate will be applied to the outstanding balance. If my insurance provider sends any payment directly to me for my treatment at Pathways, I will endorse and deliver such payment to Pathways immediately upon receipt.

Client agrees to contact PATHWAYS with an updated billing address within 30 (thirty) days of any change.



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The undersigned acknowledge that they have read the foregoing and agree to all terms, conditions, contingencies, and penalties therein, and are fully aware of the legal consequences of signing this document.

Responsible Party Signature Date

Co-Responsible Party Signature Date

Client Signature Date

Witness/Staff Date



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AUTHORIZATION FORM FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Information	
Name:	Phone:
Date of Birth:	Address:

This is to authorize the release of medical information regarding the above identified person

Name of Person/Agency:
Complete Address:
Phone/Fax Number:

Name of Person/Agency:
Complete Address:
Phone/Fax Number:

Name of Person/Agency:
Complete Address:
Phone/Fax Number:

I understand that this authorization is valid for 1 year unless revoked prior to that date.

Please fax records to Pathways Real Life Recovery at (801)-277-7593

To be disclosed, specific components being requested must be check individually:

<input type="checkbox"/> Alcoholism/Drug Abuse Treatment Records	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Psychotherapy Notes
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Biopsychosocial History
<input type="checkbox"/> Other:	

The purpose(s) of the authorization is/are:

<input type="checkbox"/> Patient Request	<input type="checkbox"/> Treatment Planning
<input type="checkbox"/> Facility Request	<input type="checkbox"/> Necessary for Evaluation
<input type="checkbox"/> Referral	<input type="checkbox"/> Other (specify):



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I Consent to the transmission of medical records VIA fax with understanding that confidentiality cannot always be guaranteed on receiving end of fax.

I understand that I may revoke this authorization at any time by giving written notice to Pathways of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the Pathways office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate after 1 year.

Client Signature

Date

Clients Legal Representative Signature

Date

Witness Signature

Date



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DURABLE POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS; this power of attorney is intended to constitute a Durable Power of Attorney under Title 26, Chapter 3, Section 7 of the Utah Statutes, THAT

I, _____, (Client name)(the “Principal”) having an address at _____ with insurance ID# _____ hereby make, constitute, and appoint each and all of:

Pathways Real Life Recovery

My true and lawful attorney-in-fact TO ACT SEVERALLY in my name, place, and stead to do and perform all and every act and thing whatsoever requisite and necessary in any way which I could or might do, if personally present, with respect to obtaining payment end or reimbursement for hospital, medical, chemical dependency treatment, and other health care services rendered to the Principal by *Pathways* whose address is *8706 S 700 E Ste 205 Sandy, UT 84070* and any of its affiliates, including, but not limited to obtaining insurance, making of claims against insurers, or other third-party payers. Instituting and prosecuting and/or defending litigation, arbitration and/or other dispute resolution proceedings, compromise and/or statement of claims and/or disputes, obtaining and/or releasing records, reports, and statements, including, but not limited to, any and all medical reports from prior treatment providers, subject to complying with federal confidentiality rules under 42 CFR Part 2, as well as all other acts which may be helpful and appropriate to the accomplishment of such purposes, for the ultimate objective of *Pathways*. Such additional acts shall include, without limitation, endorsing any draft, check, or other negotiable instrument representing insurance or other third party benefits received by or on behalf of the Principals mailing address has temporarily changed, the filing of all documents and forms which may be necessary or appropriate to maintain continued or extended health care insurance, including, by not limited to, continuation of coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”), 29 U.S.C. Section 1161 Et.seq.

Each of my said attorneys shall have full and unqualified authority to my attorney(s)-in-fact to delegate any or all of the foregoing powers to any person or persons whom my attorney(s)-in-fact select, to the maximum extent from time not forbidden by law.

The Durable Power of Attorney shall not be affected by the subsequent disability, incapacity, or incompetence of the Principal except as provided in Title 14, Article 5 of the Utah Statutes, and other specifically applicable law.

To induce any third party to act hereunder, I agree that, as against third parties, I will not question the sufficiency of any other document executed by my attorney(s)-in-fact pursuant to this Power of



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Attorney. Any third party receiving a duly executed copy or facsimile of this Power of Attorney may act in reliance hereon, and that revocation or termination hereof shall be ineffective as to such third party unless and until receipt of actual notice of knowledge thereof, and I, for myself and my heirs, executors, legal representatives and assigns, agree to indemnify and hold such third party harmless from and against any and all claims that may arise by reason of reliance upon the Durable Power of Attorney. By signing this document I confirm that I have read and understand all terms of this document, which is being initiated without duress.

Principal Signature

Print Name

Insured Signature

Print Name

Witness Signature & Print

Witness Signature & Print

Effective Date