Admission Agreements:

By signing at the end of page 5, as legal guardian I agree to all consents and releases for services on page 1-5 of these forms.

Consent for Admission: As legal guardian I consent to admit my child to Hillside for treatment and agree upon discharge to take back my child either for home/community placement or to make arrangements for ongoing treatment as a transition. I agree not to remove the child, even temporarily, from Hillside without the permission of the Medical Director or designee.

Expectations of Guardians/Parents: I understand that I am expected to attend family therapy sessions weekly and if I need to reschedule it will be within the same week. Hillside requires a minimum of 30 days for treatment to be effective and in the event that my insurance carrier feels my child is not meeting criteria for PRTF level of care before we have reached 30 days then I agree to pay out of pocket for continued stay. And that my child completing their treatment plan and meeting criteria for PRTF are two different items. If I choose not to incur out of pocket expenses then I must discharge my child on the last funded day and take home or arrange alternative placement. Finally I understand that I agree to provide follow up aftercare appointments dates, times and providers' names prior to day of discharge per insurance requirement; and that these appointments must be within 7 days of discharge for Therapist and 30 days for Psychiatrist.

Notice of Right to Request Discharge: As Legal Guardian, you may request your child’s discharge from Hillside at any time. Your child, if under the age of 18 may not request his/her discharge. The request for discharge must be in writing and a form entitled “Request for Early Discharge” will be provided for you to complete. Upon receipt of this form, the Medical Director has 3 business days to assess the child and either agrees to this request or makes a determination of at risk behaviors and involuntarily transfers the child to an acute facility for stabilization. Also as Guardian I understand that Hillside reserves the right for Program-driven Administrative Discharges that may be for noncompliance by Guardian or Child in Treatment, Therapeutic discharges, and Discharges against Medical Advice. Your Physician and Treatment Team will discuss any Programmatic Administrative discharges with you and your child as well as the rationale and timeframe for discharge.

Authorization to Provide Service: As legal guardian I am in agreement to grant specific permission to Hillside to render such medical, psychiatric services and treatment deemed necessary by the physicians with notice following treatment. Medical, Psychiatric Services and Treatment include, but are not limited to surgical care, acute inpatient hospitalization and crisis stabilization, or any other medical facility necessary for treatment and any testing including blood and urine testing for illegal substances. Also I give permission to Hillside to schedule routine dental checkups, dental treatment and emergency dental treatment unless I have made other arrangements with the Medical Director. It is understood that should time permit Hillside staff will make contact that serious medical treatment is required but cannot assume any financial responsibility for medical treatment. (Hillside shall be sole judge of whether or not time permits such notification.)
Financial Agreement: As legal guardian I understand that I am fully responsible for all services and treatment provided by Hillside. I also understand that the child is covered under private insurance, Medicaid or contracted agreement that I am responsible for obtaining and maintaining said coverage to cover claims while in treatment.

Should said child be covered by a policy that has Co-pays, Co-Insurance, or Deductibles for services provided by Hillside to also include pharmacy, labs, medical and dental, I understand that I am fully responsible for these Co-pays, Co-Insurance, and Deductibles according to my plan benefits. Any estimates provided by Hillside are only estimates and your financial responsibility may vary depending on how your insurance processes the claims.

Medications: Hillside treatment staff and/or physician will meet with you to discuss medications. Plans to receive/prescribe/administer medications will be made during the admission process. If Hillside assumes the purchasing of medications we will attempt to bill the child’s medical/pharmacy insurance. Any pharmacy copays or deductibles are the responsibility of the guardian as well as any unpaid claims for medications not covered.

Immunizations: The American Academy of Pediatrics has recommended that all children and adolescents be immunized. If your child has not already been given the appropriate vaccines then they will be administered the various vaccines in accordance to the standards set forth by the AAP. As legal guardian I consent and understand this requirement.

Authorization to Evaluate: As legal guardian I consent and agree that during the course of treatment Hillside may administer certain evaluations for treatment and discharge planning. These may include vision and hearing screening, psychological testing, achievement testing, occupational assessment, speech/language and motor testing and behavioral assessments. These tests will be part of the treatment course while at Hillside and ordered by the physician and as guardian it is understood that these are part of ongoing treatment and evaluation.

Special Procedures (ESI): If in the judgment of the Medical Director or designee it is necessary to insure the safety and well being of the child, as legal guardian I authorize the use of Emergency Safety interventions. If the child is in danger of hurting themselves or someone else in the program, the child may be placed in a Manual Hold. All Direct Care Staff at Hillside are trained in Human Empowerment and Leadership Principles (HELP). Guardians will be notified when these ESI's take place. I understand that these procedures are explained to me upon admission and in the Guardian Handbook as well as I may request a copy of the Hillside ESI Policy from Admissions at any time.

Authorization to Transport: As legal guardian I give permission for Hillside to transport my child off campus for activities, appointments etc without advance notice to myself as guardian. Hillside will notify the guardian when the child leaves campus without authorization from staff or when a significant event occurs and child has to leave campus.

Recreation Therapy: Recreation Therapy at Hillside is part of the programming and is utilized as a team/group building tool to increase self-esteem, confidence, communication skills and self awareness. The RT program involves participation in physical activities under the direct supervision of staff. Children are not forced to participate in any activity involved. As guardian I understand and grant permission for my child to participate in the Recreation Therapy program to include swimming activities and physical activities.
Therapeutic Services: Upon admission each child is assigned a therapist that will work in conjunction with the Treatment Team with the child. Hillside offers several treatment modalities besides the Dialectical Behavior Therapy (DBT). As guardian I understand that my child may also receive program services to include Animal Assisted Therapy and Theraplay and I agree to allow my child to participate in one or several of these modalities.

Cameras, Cell Phones, Videotaping, Recording Devices: Due to confidentiality of our children on campus and for HIPPA Privacy Practices, I understand as guardian that these are not allowed on campus for the purposes of recording. Also I understand that any visitors that I consent to visit on campus will also be aware that any recordings are not allowed.

Authorization to Photograph and Videotape: As legal guardian I understand and grant permission to Hillside to video/audio tape my child for safety and/or staff training purposes. All tapes are confidential and any tapes or photos otherwise will not be used without my approval. Also I agree for Hillside to photograph my child while on campus or community activities to post on campus. Photos will not identify child by name. At the same time Art Therapy may at times photograph, record or display my child’s art work for shows or events on or around campus while maintaining confidentiality and I also agree to these displays.

Authorization to Disclose Information: As legal guardian I understand that Hillside will be documenting information about my child’s behaviors and functioning and that this information may be used for program evaluation, trending and presentations. All personal identifying information will be confidential and data is presented in a statistical format.

Also as guardian I agree to Hillside contacting me via phone, email, mail or voicemail with the contact information I provide on the Emergency Contact sheet. I also authorize Hillside and its treatment providers to use and disclose information when appropriate for treatment, payment and healthcare options or with my third party payer or external review organization.

Advance Directives: As guardian I agree to provide a copy of any Advance Directives should my child have one. Also should the child be of legal age and have their own Advance Directive then they will also agree to provide a copy. The Treatment Team can review said Advance Directive and assist with any questions or issues around the Directive while in Treatment. Should the child become their own legal guardian while at Hillside and require assistance with an Advance Directive then the Treatment Team will assist with that process.

Consent for HIV Antibody Testing: As guardian I understand and consent to the fact that my child will have an HIV test; that I will be informed by a Hillside Physician or designee of the test results whether negative or positive and that these are part of the medical record; that AIDS/HIV confidential information will be disclosed to Hillside staff for purposes of treatment, to third parties for authorization issues, to Dept of Human Resources for statistics, and to future providers for discharge planning and care. By consenting to the HIV test I also understand AIDS/HIV Information and test results and that at any time can request further information from a Hillside Physician or designee.
Animal Assisted Therapy Consent:
As legal guardian I authorize my child to participate in Hillside's Animal-Assisted Therapy program. I understand that by giving my consent for participation, my child may have face-to-face contact with animals in Hillside's Animal-Assisted Therapy Program. I agree to inform Hillside of any known allergies that my child may have in relation to animals in the section below. Potential benefits to this type of therapy include motivating your child to engage in the therapeutic process, enhancing rapport with the therapist, reducing anxiety, and improving your child's ability to express feelings. As with any therapy there can be risks to treatment including the lack of a positive resolution to the presenting problem. In the case of animal-assisted therapy the risk can include an animal's nature to bite if threatened or the spread of infectious diseases. This risk is minimized with extensive training by therapists providing the therapy, careful screening of clients, routine vaccinations, regular bathing and grooming, and constant supervision of the interaction between the therapy animal and child. Your child will never be alone with an animal.

Please list any allergies that your child has to animals:

Hillside's Commitment to Your Child's Privacy: We create a record of the care and services your child receives from us in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your child's care created or retained by us. Our notice informs you of the ways in which we may use and disclose identifiable health information. We also describe certain obligations we have regarding the use and disclosure of identifiable health information, also called protected health information. Protected health information is defined as names, addresses, dates, i.e. birth date, admission date, phone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan numbers, account numbers, certificate/license numbers, vehicle identifiers numbers, device numbers, web universal locators, Internet (IP) addresses, finger prints, voice prints, full face photographic images, and any other identifying number, characteristic, or code. Hillside Authorization to Release forms are: Written, Verbal and Electronic. Electronic disclosure may be by fax, e-mail, scanning and texting. We are required by law to: Maintain the confidentiality of health information that identifies you; provide you with this notice of our legal duties and privacy practices concerning your identifiable health information; and Follow the terms of our notice that is currently in effect.

Hillside May Use and Disclose Health Information in Several Ways: Your child's health information may be disclosed for Treatment, Payment, Healthcare Operations, Appointment Reminders, Treatment Alternatives, Health-Related Benefits and Services, Individuals Involved in Your Child's Care or Payment for Your Child's Care, Research Projects, as Required by Law, and Serious Threats to Health or Safety. Use and Disclosure of Health Information in Certain Special Circumstances: Organ and Tissue Donation, Military, Workers' Compensation, Public Health Risks, Health Oversight Activities, Lawsuits or Similar Proceeding Law Enforcement, Deceased Patients and National Security. Rights Regarding Your Child's Health Information: You have the right to: Inspection and request of information, Amendment of information, Accounting of disclosures of information, Right to request restrictions, Confidential communications, please make requests in writing; and Right to a paper copy of this notice. We reserve the Right to Revise Our Privacy Notice. If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services, Washington, D.C. To file a complaint with the facility contact: Hillside, Attention: Privacy Officer, 600 Courtenay Drive, NE, Atlanta, Georgia 30306, 404-875-4551 x294 or Office for Civil Rights, U.S. Department of Health and Human Services, Sam Nunn Atlanta Federal Center, Suite 16710, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909, or Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F - HHH Bldg., Washington, D.C. 20201, 1-877-696-6775.
I have received the summary of Hillside Notice of Privacy Practices. I acknowledge, I may request a detailed version at any time. I have been informed and received copies regarding the following: 1. Invitation to Treatment Planning, 2. Parent Handbook, 3. Emergency Safety Interventions, 4. Rights Afforded by Section 504 of the Rehabilitation Act, 5. Notice of Privacy Practice, 6. Hillside staff contact information, 7.Treatment Program and Level System, 8. Insurance Denials and Appeals process. By signing below, as legal guardian I agree to all consents and releases for services on pages 3-5 of this form.

__________________________  ______________________  ______________________
Legal Guardian                Date                     Witness
Authorization for Use and Disclosure of Education Records

Student Name: ___________________________  DOB: _______  Grade: _______

Does the student currently receive Special Education Services? ______

Eligibility Date: _______________  Eligibility Area: _______________________

As Guardian, I request and authorize:

Previous School Name: ___________________________

School Address: ____________________________________________

School Phone: ___________________________

To disclose the following records as written, verbal, and/or electronic and authorize the sharing of educational information between Hillside and Current School:

___ Report Card/Transcripts
___ Withdrawal Form
___ 504 Plan (if applicable)
___ Copy Birth Certificate, Social Security Card, Insurance/Medicaid Card
___ Current Medical and Dental Records
___ School Approved Immunization Form including status of Hep-B Vaccination

Special Education Records (if applicable):
___ Current IEP
___ Initial Eligibility Report
___ Re-evaluation Determination
___ Psychological Evaluation(s)

I consent to the release of the above Educational Records for purposes of enrollment at Hillside Conant School and for treatment at Hillside.

________________________  ______________________  ______________________
Legal Guardian  Date  Witness
Authorization for Notification of Procedures

During the course of treatment it may be necessary to use some of the following procedures with your child. I understand that I may choose to be notified at the time of each procedure or through the written monthly summary. Please check which notification you would like to receive:

I authorize Hillside to leave voicemail containing information at:

Mobile: ___________________ or Phone: ___________________

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Immediate Notification at time of procedure</th>
<th>Notification on 30 day Written Summary</th>
<th>If scheduled appointment notify in advance so I may attend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication dosage change—new meds require prior approval</td>
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<tr>
<td>Illness or Injury requiring non psychiatric medications</td>
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<tr>
<td>Injury that does not require treatment off campus</td>
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<tr>
<td>Routine Dental Exam</td>
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<tr>
<td>Routine Vision Exam</td>
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<tr>
<td>Medical Appointments off campus</td>
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<tr>
<td>Illness that requires treatment at Pediatrician</td>
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<tr>
<td>Vaccinations</td>
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<td></td>
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<tr>
<td>Unit Transfer—may occur prior to event</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Use of Seclusion—may occur prior to event</td>
<td></td>
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<tr>
<td>Name</td>
<td>Relationship</td>
<td>On/Off Campus</td>
<td>Mobile</td>
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</tbody>
</table>

Guardian ____________________________ Date ____________ Witness ____________________________
Authorization for Release of Treatment Information/Medical Records

Section I: Requesting/Releasing Party Information

I request and authorize Hillside:
- [ ] To release to: [ ] To obtain from:

Professional/Facility/Agency Name

Address

City, State, Zip

Phone Number

Fax Number

Section II: Types Of Information To Be Released (please be specific)

- [ ] Discharge Summary
- [ ] History & Physical
- [ ] Psychiatric Evaluation/Admit Note
- [ ] HIV/AIDS Confidential Information
- [ ] Treatment Plans
- [ ] Psychosocial History
- [ ] Physician’s Orders
- [ ] Psychological Evaluation
- [ ] Laboratory results
- [ ] Discharge Plan
- [ ] Verbal communication/consultation
- [ ] Other:

Section III: Method of Transmission

- [ ] Verbally in person or by phone
- [ ] Email
- [ ] Fax
- [ ] Photocopy

Section IV: Purpose For The Release

- [ ] At the request of the client/client representative
- [ ] Payment/Insurance
- [ ] Social Security/disability
- [ ] Evaluation/Treatment/Continuity of Care
- [ ] Legal
- [ ] Other (state reason)

Section V: Expiration Of Authorization

I understand that this authorization will remain in effect for (check one):
- [ ] 90 days post discharge
- [ ] 90 days from the date of my signature
- [ ] Other date:

Section VI: Signature(s)

I understand that records released may contain HIV/AIDS, alcohol/drug treatment information or psychiatric/psychological information. Hillside and many other organizations and individuals such as physicians, hospitals and health plans are required by law (42 CFR Part 2 & 45 CFR 160/164) to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. I acknowledge that I am not under any force or duress, and that my decision concerning disclosure of information is not contingent to provision of service.

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE ___________________________ DATE ____________

If signed by legal representative, relationship to client: ______________________________________

Section VII: Withdrawal of Authorization

I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and present my written withdrawal to the releasing person/agency. I understand that the withdrawal will not apply to information that has already been released in response to this authorization.

I withdraw this authorization to release information:

SIGNATURE ___________________________ DATE ____________
Authorization for Release of Treatment Information/Medical Records

Section I: Requesting/Releasing Party Information

I request and authorize Hillside:  
☐ To release to:  ☐ To obtain from:  
Name of Healthcare Provider (check both)

Professional/Facility/Agency Name
Enter contact information for healthcare provider in this section
Address
City, State, Zip

Phone Number  Fax Number

Section II: Types Of Information To Be Released (please be specific)

☒ Discharge Summary  ☑ Treatment Plans  ☑ Laboratory results
☒ History & Physical  ☑ Psychosocial History  ☑ Discharge Plan
☒ Psychiatric Evaluation/Admit Note  ☑ Physician’s Orders  ☑ Verbal communication/consultation
☒ HIV/AIDS Confidential Information  ☑ Psychological Evaluation  ☐ Other:

Section III: Method of Transmission

☒ Verbally in person or by phone  ☑ Email  ☑ Fax  ☑ Photocopy

Section IV: Purpose For The Release

☒ At the request of the client/client representative  ☑ Evaluation/Treatment/Continuity of Care
☐ Payment/Insurance  ☐ Legal
☐ Social Security/disability  ☐ Other (state reason)

Section V: Expiration Of Authorization

I understand that this authorization will remain in effect for (check one):
☒ 90 days post discharge  ☑ 90 days from the date of my signature  ☐ Other date:

Section VI: Signature(s)

I understand that records released may contain HIV/AIDS, alcohol/drug treatment information or psychiatric/psychological information. Hillside and many other organizations and individuals such as physicians, hospitals and health plans are required by law (42 CFR Part 2 & 45 CFR 160/164) to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. I acknowledge that I am not under any force or duress, and that my decision concerning disclosure of information is not contingent to provision of service.

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE:  
Client/Legal Guardian Signs Here  DATE: Date Here

If signed by legal representative, relationship to client:  

Section VII: Withdrawal of Authorization

I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and present my written withdrawal to the releasing person/agency. I understand that the withdrawal will not apply to information that has already been released in response to this authorization.

I withdraw this authorization to release information:  Leave this blank. For withdrawal of consent only.

SIGNATURE  DATE
Authorization for Release of Information and Consulting Medical Services

As Guardian, by signing this agreement I am granting specific permission to render medical services and treatments as deemed necessary by Physicians. These services include, but are not limited to dental, emergency care, lab work, surgical care, radiology, diagnostic testing procedures and hospitalization. I also authorize release of information regarding such services received to Hillside for continuation of treatment. I further authorize Hillside to release information to these providers for continuation of treatment and that this information will be limited to what is necessary for the services rendered by the providers. Information will be released as written, verbal and/or electronic.

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Information to be Released</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Healthcare of Atlanta Egleston and Scottish Rite</td>
<td>Allergies, H&amp;P, Insurance information, Doctors Orders, Authorization for Treatment, Medications, Routine Appointments and Medical Referral</td>
</tr>
<tr>
<td>Kool Smiles (Dental)</td>
<td>Allergies, Insurance information, Authorization for Treatment, Medications and Medical Referral</td>
</tr>
<tr>
<td>Lab Corp</td>
<td>Insurance Information</td>
</tr>
<tr>
<td>Stone Mountain Eye Care Center</td>
<td>Allergies, Insurance information, Authorization for Treatment, Medications and Medical Referral</td>
</tr>
<tr>
<td>Kenmar Pharmacy</td>
<td>Allergies, Insurance Information and Medications</td>
</tr>
</tbody>
</table>

I understand that medical, alcohol/drug and psychiatric treatment records may be protected by federal regulations (942 CFR Part 2). I give consent to release information and understand that I may revoke this consent at any time.

__________________________________________  __________________________  __________________________
Legal Guardian                                    Date                                    Witness

Rev 5/18
As legal guardian, I have been offered a copy and understand the Vaccine Information Statement below and authorize the vaccines checked to be given to the patient including the Annual Flu Vaccine and to the inclusion of this data into the Georgia Registry of Immunizations Transactions and Services.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Guardian</th>
<th>Date</th>
</tr>
</thead>
</table>

Vaccines to be administered:
- DT
- DTaP
- Tdap
- Td
- HepA
- HepB
- Hib
- HPV
- Influenza
- Meningococcal
- MMR
- PCV7/13
- PPV23
- Polio/IPV
- Rotavirus
- Varicella
- Other
- Flu shot/spray

Primary Care Physician: __________________________ Phone: __________________________
Address: ________________________________________

Immunization Screening regarding Patient:
- Currently sick or with high fever?
- History of serious reaction to vaccines? Serious reaction to flu vaccine?
- Any allergies that produce a severe (anaphylactic) reaction? Allergy to eggs?
- Had Guillain-Barre Syndrome within 6 weeks of flu vaccine?
- Has your child been vaccinated with any vaccine in last 30 days? If so which one and date?
- Any history of asthma, diabetes or disease of heart, lung, kidneys, liver, nerve or blood?
- History of Seizure or other neurological problem?
- Any Medical Problems that make it hard to fight infections?
- Have close, regular contact with someone with a weakened immune system?
- Is the patient taking corticosteroids or other steroids, or anti-cancer drugs, or had x-ray treatments?
- Received blood, plasma, or immune globulin in the past 12 months?
- Currently pregnant or thinking of becoming pregnant within the next 3 months?
Hillside Conant School Free and Reduced Meal Screening Eligibility

Admission Date: ______

Student Name: ______________________  DOB: ______

Does the Student have personal income? Yes or No
(Personal income is: job/employment or family trust or trust fund of student only. Social Security is not considered income)

If yes, please provide Personal Income Amount: $___________ / weekly, biweekly, monthly

I verify the information is true to my knowledge.

Parent/Legal Guardian/Responsible Party: ____________________________

The US Dept of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities).
Great News! The Help a Child Smile dental program has partnered with your child’s school to offer full-service dental care at the school.

Dental care is very important for your student’s health.

Easy & Convenient... Has your child visited another dentist within the last 12 months? If not, they can enroll.

IF YOUR CHILD ALREADY HAS A DENTIST YOU SHOULD KEEP GOING TO THAT DENTIST.

TOTAL DENTAL CARE

Our complete dental care includes an exam, x-rays, cleaning, fluoride, sealants, and cavity treatment when needed.

<table>
<thead>
<tr>
<th>School:</th>
<th>County:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Name:</td>
<td>M_F</td>
</tr>
<tr>
<td>Primary Phone:</td>
<td>Day Phone:</td>
</tr>
<tr>
<td>Address:</td>
<td>Apt:</td>
</tr>
<tr>
<td>Email:</td>
<td>Grade:</td>
</tr>
</tbody>
</table>

CHILD HAS MEDICAID/PEACHCARE:

| Enter Child’s 12 digit Medicaid Recipient ID Number HERE: |
| Medicaid & Peachcare cover 100% of treatment |

CHILD HAS PRIVATE INSURANCE: Insurance Co. Name: Phone # of Co: Policy Holder’s Name: Policy Holder’s DOB: Policy Holder’s # or SS #: Employer: CHILD IS UNINSURED: [Circle One] Check, Credit Card or Cash

CHILD’S MEDICAL HISTORY

Check each condition that applies to your child:

- Recent Dental Problems
- Allergy to Medications/Other
- Asthma or Wheezing
- Rhematoid Fever
- Diabetes
- Hemophilia/Bleeding Problems
- Pregnant
- Sickle Cell Anemia
- Epilepsy/Seizures
- User Problems/Hepatitis
- Kidney Problems
- HIV/AIDS
- Cancer
- Tuberculosis
- Communications Disease
- Wheelchair Access
- Heart Condition (describe below)

Notify us of any medical history. A thorough and complete medical and dental history is important for a proper dental examination and evaluation.

List allergies to medications:

Name/phone # of child’s physician:

Use space below to provide additional details on your child’s health, including current medical treatment, other significant past illnesses, alcohol & tobacco use (including smokeless). List current medications and premedication if needed for dental treatment.

READ AND SIGN BELOW:

I understand and authorize Mark Shurett, DDS, PC (Provider) and its affiliated dentists to provide the following services for the above-named child for whom I am the custodial parent or legal guardian: dental exam, tooth cleaning, fluoride treatment, x-rays & dental sealants. I authorize the dentist to take any steps or to place a stainless steel crown over the tooth if needed. I authorize Provider to extract any problem baby teeth or provide a baby root canal (removal of the nerves inside the tooth) as needed. I understand that there are risks to dental treatment including swelling or pain that may occur from the injection of a local anesthetic or allergic reaction. (For additional information regarding the risks of treatment and treatment alternatives, please call the number below.) I authorize & direct Provider to bill & collect payment from any insurance, including, or other payers. If I have private dental insurance, I will be billed for & agree to pay any deductibles and/or co-pays. Unless I have made pre-arrangements to attend, and am there at the time of service, services will be provided without my presence. I have received the Notice of Privacy Practices attached to this form and consent to the release of my child’s medical record information as described therein.

You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the landline and/or mobile telephone numbers provided on this consent form.

This signed consent authorizes my child’s initial dental visit and follow-up visits. I may withdraw this consent at any time in writing to the address below.

For your privacy, please fold & secure.

SIGN HERE

PRINT NAME

DATE

Mark Shurett, DDS, PC 1809 Overlake Dr., Cooper, GA 30625 Visit us at: hoagds.com Phone: (850) 773-2388 Fax: (850) 745-8042

[Signature]

[Date]
Appendix 3

AGREEMENT REGARDING ADMISSION TO A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) FOR PARENT/LEGAL GUARDIAN or YOUNG ADULT WITH NO LEGAL GUARDIAN

This agreement concerns the admission of the below named youth/young adult into a Psychiatric Residential Treatment Facility and the responsibilities of the said youth parent/legal guardian or young adult.

<table>
<thead>
<tr>
<th>Name of Youth/Young Adult</th>
<th>Date of Birth</th>
<th>Legal Guardian</th>
</tr>
</thead>
</table>

My initials to the left of each statement and my signature below indicate my agreement with the following:

Section I — to be completed by ALL parents/legal guardians of youth or young adults with no legal guardian

_**_ I am the parent or legal guardian (circle one) of the above named youth/young adult who consented to my child/young adult’s treatment in PRTF.

_**_ I am a young adult (18-21 years old) with no legal guardian who consented to treatment in a PRTF.

_**_ If I am no longer a legal resident of Georgia, I/my child may no longer be eligible for funding.

_**_ I agree to pay for all personal expenses for my child not covered by the PRTF payment rate - such expenses include, but are not limited to, medical expenses not covered by Medicaid or other insurance, clothing, personal allowances, birthday and holiday gifts, and transportation home or as a young adult I am responsible for all of my personal expenses not covered by the PRTF payment rate.

_**_ I agree to maintain regular contact with my child/young adult through frequent visits to the PRTF, periodic home visits as appropriate, telephone contact, and other communication.

_**_ I agree to participate in treatment planning beginning with admission and continuing throughout my/my child/young adult’s stay.

_**_ I agree to participate in the supports provided to prepare for my/my child/young adult’s return home, including consistent contact with the PRTF to ensure mutual agreement and cooperation regarding the care and services provided, and providing PRTF staff with information, recommendations, and cooperation regarding my care or the care of my child/young adult.

_**_ I agree to participate in discharge planning for me/my child/young adult to return home; if for any reason I am/my child/young adult is not discharged home, I agree to identify an appropriate placement.

_**_ I agree to allow the Department of Behavioral Health & Developmental Disabilities (DBHDD) and other provider agencies to have access to, and share information relating to my/my child/young adult’s medical, behavior management, treatment, and placement needs.
___ I agree to maintain contact with the local manager, including behavioral health, DFCS and/or DJJ, and inform him/her of any changes which may affect my/my child/young adult's treatment.

___ I agree to participate in the gathering of outcome data regarding the care provided to me/my child by fully cooperating with provider agencies in the sharing of information related to my/my child/young adult’s circumstances and life situation at regular intervals during and following discharge, participate in, or allow my child/young adult to participate in, consumer satisfaction surveys.

Section II - to be completed by parent/legal guardian of uninsured youth OR young adult with no legal guardian

___ I understand that application for Indigent/State Funds to pay for PRTF services was made to the Department of Behavioral Health & Developmental Disabilities on my behalf or on behalf of my child/young adult.

___ I attest that there is no current primary insurance benefit that covers residential treatment for me/my child/young adult.

___ I agree to pursue any resource or benefit /my child/young adult may be eligible for such as Medicaid, PeachCare, SSI, or private insurance at admission or within fifteen (15) business days of admission.

___ I understand that failure to apply for other financial benefits within the designated timeframe will result in discontinuation of funding by DBHDD in sixty (60) days of admission.

___ I understand that as an uninsured young adult or parent/legal guardian of an uninsured child/young adult, I have no appeal rights if DBHDD seeks to deny, terminate, or suspend PRTF level of care services.

___ I agree to notify the PRTF if /my child/young adult becomes eligible for insurance benefits through a new insurance policy, or through a change, update, or replenishment of a current policy.

Section III – to be completed by parent/legal guardian of youth OR young adult with no legal guardian committed to the Department of Juvenile Justice (DJJ)

___ I am/my child/young adult is committed to the Department of Juvenile Justice. Date of Commitment is ____________________________

___ I/my child/young adult was placed/living at the following location immediately prior to admission to the PRTF:

____________________________

Section IV – to be completed by Medicaid Recipients

___ I understand that I have the right to request an Office of State Administrative Hearings (OSAH) hearing if DBHDD seeks to deny, terminate, or suspend PRTF level of services.

Agreement Regarding Admission to a PRTF for Parent/Legal Custodian [15]
I understand that if a fair hearing is requested, I have the ability to be represented by an attorney or other representative for whom I am financially responsible.

I understand that I will be responsible for paying all PRTF level of services after the date that the External Review Organization determines that I/my child/young adult no longer will meet criteria unless the Office of State Administrative Hearings makes a ruling to overturn that determination.

Section V – Declaration of Citizenship (information used only to determine eligibility for public benefit) - to be completed by parent/legal guardian of youth OR young adult with no legal guardian

I am/my child is a United States citizen.

I am/my child is a legal permanent resident of the United States.

I am/my child is a qualified alien or non-immigrant under Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. My/my child alien number issued by the Department of Homeland Security or other federal immigration agency is:

Section VI – to be completed by parent/legal guardian of youth OR young adult with no legal guardian

I hereby attest that I understand the above statements and I have provided accurate information. I will be held responsible for any and all costs for me/my child/young adult in the PRTF and I will reimburse the Department of Behavioral Health & Developmental Disabilities for payments made on my behalf or on my child/young adult's behalf if I willfully fail to disclose information related to this agreement.

Signature of Young Adult (no Legal Guardian) Printed Name of Young Adult Date

Signature of Parent/Legal Custodian Printed Name of Parent/Legal Custodian Date

Signature of Witness Printed Name of Witness Date

Copy to: PRTF File
Department of Behavioral Health & Developmental Disabilities for Uninsured and/or DJ Committed Youth/Young Adult

Agreement Regarding Admission to a PRTF for Parent/Legal Custodian
EMERGENCY CONTACT INFORMATION

Patient Name: ____________________________

Hillside may contact the legal guardian and/or all of contacts listed below:

Legal Guardian: ____________________________ Relationship ____________________________

Cell Phone ____________________________ Home Phone ____________________________

Work Phone ____________________________ Emergency Phone ____________________________

Address ________________________________________________________________

Email __________________________________ Fax ____________________________

Emergency Contact: ____________________________ Relationship ____________________________

Cell Phone ____________________________ Home Phone ____________________________

Work Phone ____________________________ Emergency Phone ____________________________

Address ________________________________________________________________

Email __________________________________ Fax ____________________________

*** Mandatory for all DFCS placements***

DFCS: Caseworkers Supervisor: ____________________________ Phone ____________________________

Email ____________________________ Fax ____________________________