FOUR CIRCLES RECOVERY CENTER
CLIENT EMERGENCY - SUMMARY INFORMATION

CLIENT'S NAME: _____ DATE OF BIRTH: _____
Physical Description: Age: _____ Ht: _____ Wt: _____ Eyes: _____ Hair: _____
Identifying Feature(s): _____ Shoe Size: _____ Waist: _____ Shirt Size: _____

Please List Any MEDICATIONS that you are CURRENTLY taking and bringing or indicate NONE. All Medication "MUST" include a Prescription & be in the correct Containers. All medications (including Vitamins & Acne Creams) must include clear doctor's prescriptions, or they will not be dispensed. If you have been given verbal directions to change dosage or time of administration, we must receive a signed and dated fax from the prescribing doctor with the current orders.

Medication Dosage/Amount Sending AM/PM Date Prescribed Reason Taking

_____
_____
_____

Please List any previously experienced Medication reactions/side effects:
_____

Do you have a History of Refusing to take Medication? If so, Please List what reactions, or side effects might occur:
_____

Please list any major illness or physical injury that was suffered by your child previously:
_____
_____

Please List Any ALLERGIES, SPECIAL MEDICAL CONDITIONS OR DIETARY CONCERNS that effect you, including reactions to Poison Ivy, Latex, Insect Bites, or Shellfish:
Allergy/Condition Specify Reactions & History

_____
_____

Vegetarian: Yes ____ No ____

Do you Require the Following: (Please Circle Appropriate Answer)

Prescription Eyewear	Yes	No	Glasses are preferred, please send in container
Dental Retainer	Yes	No	Please Send Container

Please List Any Additional Information that is NECESSARY for your care:
_____
_____

Contact Information:

Father: _____	Mother: _____	Referral Source Name:
Hm Ph:_____	Hm Ph:_____	_____
Wk Ph:_____	Wk Ph:_____	Ph: _____
Cell Ph:_____	Cell Ph:_____	

Arrival Information- flying or driving
Airline: _____ Flight: _____ Arrival Time: _____ Escort: _____
City of last leg of flight arriving from/ or meeting place (driving) : _____ Color of carry-on bag: _____

Authorization for Release of Information

Program Name: **Four Circles Recovery Center**

I, _____,

Date of birth: _____, Social Security #: _____,

I hereby authorize Four Circles Recovery Center, to release to (names)_____,

the below specified information; and release the above named organization(s) / individual(s) from all legal liabilities that may arise from this situation.
Information to be released**:**_____

I hereby authorize the following person(s)/agencies_____

To release personal/healthcare information to Four Circles Recovery Center; and release the above named organization(s) / individual(s) from all legal liabilities that may arise from this situation.

Information to be released**:**_____

Purpose of this release of information: to facilitate continuity of care

I understand that information regarding my alcohol and / or drug treatment is protected by federal law under the Drug Abuse Prevention, Treatment, and Rehabilitations Act and the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and their implementing regulations. See generally 42 C.F.R. Part 2; 45 C.F.R. Parts 160, 164. I understand that my health information specified above will be disclosed pursuant to this authorization, that the recipient of the information may re-disclose the information and it may no longer be protected by federal law under HIPAA. Federal law governing confidentiality of alcohol and drug abuse patient information, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that this consent will expire in one (1) year unless otherwise specified below:

Specification of the date, event or condition upon which this consent expires (Date)_____
I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form.

Authorizing Signature: _____ Date: _____

Witness: _____ Date: _____

Confidentiality of Records

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal law (see 42 C.F.R. Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of information is not sufficient for this purpose. This authorization for release of information may be considered as an original in instances of fax or electronic transmittal.

Four Circles Recovery Center

Authorization and Consent to Engage in Follow-Up

I, _____, hereby
(Client's Name)
authorize Four Circles Recovery Center to contact me by telephone or mail and/or to contact any resources to which I have been referred by Four Circles Recovery Center. I understand that the contact is done to follow-up on treatment instituted at Four Circles Recovery Center. I further understand:

1. Staff members of Four Circles Recovery Center will conduct the telephone or mail follow-up contacts.
2. Follow-up contacts will seek information regarding my current condition and activities.
3. The purpose for follow-up contacts includes such areas as determining my use of my post-treatment continuing care plan, reviewing my progress, and soliciting my suggestions for improvement of programs of Four Circles Recovery Center.
4. I may revoke consent to follow-up contact at any time in writing and by forwarding the revocation to Four Circles Recovery Center, as specified in applicable mental health and alcohol and other drugs laws and regulations of the State of North Carolina, Subpart C, Code of Federal Regulations, Volume 40, Number 27, July 1, 1975., and the Health Insurance and Portability Act of 1996 (HIPAA).
5. Without written revocation, this consent expires one (1) year after the termination of treatment or for the following:
   A. Event: _____
   B. Condition: _____
6. In the event that I cannot be reached by Four Circles Recovery Center, I hereby authorize Four Circles Recovery Center to contact the following persons for information about my condition, progress, etc.

_____ _____
Name Relationship

_____ _____
Address Telephone Number

_____ _____
Name Relationship

_____ _____
Address Telephone Number

_____ _____
Client's Signature Witness' Signature

_____ _____
Date Date

At Exit: I can be contacted at the following telephone number: _____

NOTICE OF PRIVACY PRACTICES

OF

ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES

Effective Date: 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.

If you have any questions about this notice, please contact Ruth Moore, AEG

WHO MUST FOLLOW THE REQUIREMENTS OF THIS NOTICE?
Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Aspen Education Group and its affiliated entities (collectively, "Aspen") must take steps to protect the privacy of your "protected health information" (referred to in this Notice as "PHI" or "health information"). PHI includes information that we have created or received regarding your health or payment for your health. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

Aspen Education Group is an organization that is committed to improving the quality of life for youth and their families. Aspen operates 48 programs in nine states that provide innovative quality educational programs that promote academic and personal growth. The services provided by Aspen's programs are diverse and, in some cases, the provision of health care treatment and services may be the primary function – for example, the provision of mental health services by Aspen Community Services – or, in other cases, the provision of health care treatment may be a secondary or ancillary function -- for example, a nurse's office located on an Aspen school campus. Aspen also operates an employee benefit health plan for the benefit of its employees.

All of these programs, functions and services operated or provided by Aspen are conducted through separate but affiliated entities which are identified on Exhibit A attached to this Notice. Under the privacy standards contained in HIPAA, legally separate but affiliated entities may designate themselves as a single covered entity for compliance purposes. Accordingly, this Notice constitutes notice of the privacy practices for all of the Aspen-affiliated entities, sites and locations that are listed on the attached Exhibit A, which will follow the terms of this Notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment or health care operations purposes as described in this Notice. All Aspen employees are required to maintain the confidentiality of PHI in accordance with this Notice and receive appropriate privacy training.

Please note, however, that this Notice of Privacy Practices does not apply to student medical records that are maintained by Aspen's four special education day schools in Southern California -- Hawthorne Academy, Rossier Park High School and Elementary School, and Leeway School. The reason is that these schools are subject to the Federal Educational Rights and Privacy Act ("FERPA") resulting from their receipt of indirect funding from the U.S. Department of Education. The privacy rights and protections afforded to student medical records maintained by those schools will be governed by FERPA instead.

NOTICE - CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS
Per 42 CFR, Chapter 1, Part 2
The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:
1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to designated and qualified staff for research, audit, or program evaluation
Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.
Federal law and regulations do not protect any information about a crime conunitted by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.
Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate state or local authorities.

RESPONSIBILITIES OF ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES
We are required by law to:
- Make sure that health information that identifies you is kept private (with certain exceptions);
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of this Notice that are currently in effect.

This Notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BY ASPEN THAT DO NOT REQUIRE YOUR AUTHORIZATION
Aspen uses and discloses protected health information in a number of ways connected to the provision of health care treatment and services, payment for care, and our health care operations. Some examples of how we may use or disclose your health information without your authorization are listed below.

We may use or disclose your protected health information without your authorization as follows connected to the provision of health care treatment and services:
- To physicians, nurses, and others involved in your health care or preventive health care.
- To other health care providers treating you such as hospitals, pharmacies, labs, emergency room staff and specialists. For example, if you are being treated for an injured knee, we may share your health information among your primary physician, the knee specialist, and your physical therapist so they can provide proper care.

We may use or disclose your protected health information without your authorization as follows in relation to payment for care:

- To administer your health benefits policy or contract (for Aspen Education Group Employee Benefit Plan members).
- To bill you for health care we provide.
- To pay others who provided care to you.
- To other organizations and providers for payment activities unless disclosure is prohibited by law.

We may use or disclose your protected health information without your authorization as follows in relation to health care operations:

- To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we may use your health information to review and improve the quality of care you receive, to provide training, and to evaluate the performance of our staff in caring for you.
- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your health information with other organizations for this purpose, they must agree to protect your privacy.)

We may use or disclose your protected health information without your authorization for legal and/or governmental purposes in the following circumstances:

- As required by law -- When we are required to do so by federal, state or local law.
- Public health and safety -- To an authorized public health authority or individual for public health and safety purposes, including to:
  - Protect or prevent a serious threat to the health and safety of the public or of another person.
  - Prevent or control disease, injury, or disability.
  - Report vital statistics such as births or deaths.
  - Report reactions to medications or problems with products and notify people of recalls of products they may be using. (Food and Drug Administration.)
  - Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
  - Notify an employer concerning work-related injuries or illnesses or workplace medical surveillance in situations where the employer has a duty under federal or state law to keep records on or act on such information.
- Abuse or neglect -- To the appropriate government authority authorized to receive reports regarding abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law. However, no consent is required in cases involving child abuse or neglect.
- Health oversight activities -- To health oversight agencies for certain activities such as audits, investigations, inspections and licensure.
- Lawsuits and disputes -- In the course of any legal proceeding, in response to an order of a court or administrative agency. Also, in certain cases, in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- Law enforcement -- To law enforcement officials in limited circumstances for law enforcement purposes. For example disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.
- Military activity and national security – To the military (if you are a member of the armed forces), and to authorized federal officials for national security and intelligence purposes or in connection with providing protective services to the president of the United States.
- Workers' compensation – Where authorized by law in order to comply with the workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

We may also use or disclose your protected health information without your authorization in the following miscellaneous circumstances:

- Facility directory information -- Unless you object, we may use and disclose your name, the location at which you are receiving care, your general condition (e.g., fair, stable, etc.), and your religious affiliation in our facility directory. All of this information except religious affiliation will be disclosed to people who ask for you by name. Members of the clergy (such as a priest or rabbi) will be told your religious affiliation if they ask (but they don't have to ask for you by name). This is to help your family, friends, and clergy visit you in the facility and generally know how you are doing.
- Family and friends – Unless you object, we may disclose health information about you to a family member, relative, a close friend - or any other person you identify who is directly involved in your health care - who is involved in your care or who helps pay for your care. If you are either not present or unable to make a health care decision for yourself and we determine that disclosure is in your best interest, we may also disclose such health information about you to those persons. For example, we may disclose health information to a friend who brings you into an emergency room.
- Appointment reminders – To remind you that you have a health care appointment with us. These reminders may be made by postcard, phone, or voicemail unless you specifically ask us to communicate with you through a different method as described later in this Notice.
- Treatment alternatives and health-related services -- To communicate with you about treatment services, options, or alternatives, as well as health-related benefits or services that may be of interest to you.
- Employer group health plans – For Aspen Education Group Employee Benefit Plan members, we may communicate with your employer for certain administrative activities.
- Health insurance underwriting -- For Aspen Education Group Employee Benefit Plan members, we may use your health information for underwriting, premium rating or other health insurance-related activities
- Research - For research purposes provided that certain steps are taken to protect your privacy. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the facility
- De-identify information -- To "de-identify" information by removing information from your health information that could be used to identify you.
- Disaster relief -- To an authorized public or private entity for disaster relief purposes. For example, we might disclose your health information to help notify family members of your location or general condition.
- Coroners, funeral directors, and organ donation -- To coroners, funeral directors, and organ donation organizations as authorized by law.
- Correctional institution -- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official for certain purposes, such as (1) providing health care to you by the institution; (2) protecting your health and safety or the health and safety of others; or (3) protecting the safety and security of the correctional institution.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BY ASPEN THAT REQUIRE US TO OBTAIN YOUR AUTHORIZATION

Except in the situations listed in the sections above, we will use and disclose your health information only with your written authorization. If you sign an authorization you may revoke it at any time in writing, although this will not affect information that we disclosed before you revoked the authorization. If you would like to ask us to disclose your health information, please contact the Aspen Privacy Officer at (562) 467-5500 for an authorization form. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the right to:

- Restrictions on use or disclosure -- Request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Please note that we are not required to agree to your request. If we do agree, we will honor your limits unless it is an emergency situation. To request restrictions, you must make your request in writing to the Aspen Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- Confidential Communications – Request that we communicate with you about health matters by another means or at another location. For example, if you want us to communicate with you at a different address we can usually accommodate that request. Any request must be made in writing to the Aspen Privacy Officer. Your request must specify how or where you wish to be contacted. We will agree to reasonable requests.
- Inspect and copy -- Inspect and copy health information that may be used to make decisions about your care. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Aspen Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. In certain situations we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.
- Amend -- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Aspen. To request an amendment, your request must be made in writing and submitted to the Aspen Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for Aspen;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

- Accounting of disclosures – Request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, (as those functions are described above) and for other exceptions pursuant to the law. To request this list or accounting of disclosures, you must submit your request in writing to the Aspen Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Paper copy -- Request a paper copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

CHANGES TO PRIVACY PRACTICES

Aspen may change the terms of this Notice at any time. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. If we change any of the practices described in this Notice, we will post the revised Notice on enrollee-accessible web sites and at Aspen clinic sites. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Aspen or with the Secretary of the Department of Health and Human Services. To file a complaint with Aspen, write to Ruth Moore, Vice President, Corporate Compliance, at 17777 Center Court Drive, Suite 300, Cerritos, CA 90703. For more information on how to file a written complaint, contact the Aspen Privacy Officer at (562) 467-5500. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

QUESTIONS If you have any questions about this Notice or would like an additional copy, please contact the contact the Aspen Privacy Officer at (562) 467-5500.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Aspen Education Group and its affiliated entities. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our Notice, you may request a copy of the revised notice by accessing our web site (http://www.aspeneducation.com) or contacting our organization at (562) 467-5500. If you have any questions about our Notice of Privacy Practices, please contact Aspen's Privacy Officer at (562) 467-5500.

I acknowledge receipt of the Notice of Privacy Practices of Aspen Education Group and its Affiliated Entities.

Signature: _____ Date:_____
(individual/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT
[To be completed only if no signature is obtained.]

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Aspen representative: _____ Date: _____

Four Circles Recovery Center
ADMISSIONS OFFICE: 156 Clear Crossing Lane, Horse Shoe, NC 28742
Phone (828) 891-2221 (877)-893-2221 Fax (828) 891-2224

PHARMACY/CLINIC FORM

We will do our best to process the prescription(s) through your insurance, but please understand that some insurance companies do not contract with all pharmacies. You are fully liable for any balance not paid by your insurance. **The pharmacy Four Circles uses will not process prescriptions through your insurance without a copy of both sides of your insurance card.**

Prescription Drug Coverage Information

Client Name (please print) _____ Date of Birth _____

Client's Social Security # _____ Relationship to Subscriber _____

Name of Subscriber _____ Subscriber's Date of Birth _____

Name of Ins. Carrier _____ Phone Number ( ) _____

Address _____ City _____ State _____ Zip _____

Group # _____ Subscriber ID # _____

* * * * *

We require that you submit a credit card number to cover the initial physical, medication(s), and any other medical expenses.

I authorize Four Circles Recovery Center to use my credit card for any medical services that are incurred for the duration of the program.

Credit Card Number

Credit Card Type: _____ **Exp Date** _____ **CVV #** _____

✍ **Authorized Signature:** _____ **Date:** _____

Four Circles Recovery Center Application

Parent Authorization and Consent for Electronic Communications

I/we authorize Four Circles Recovery Center to transmit personal communications from my child to me by facsimile.

Please send all client communications to me at the following number:

FAX NUMBER: _____

EMAIL ADDRESS: _____

Circle one of the following:

SECURE The above fax/email is secure, please send without notification.

NOT SECURE The above fax/email is NOT SECURE, please contact me at the following number prior to any transmission.

Call to Notify at: _____

TRANSMISSION ERRORS

I/we understand that errors sometimes occur in the transmission of personal communications between client and parents. I/we release Four Circles Recovery Center from any and all liability for errors in the transmission of personal communications between my child and myself.

I/we agree to keep confidential the nature of any communication that I/we may receive in error and to notify Four Circles Recovery Center immediately.

Mother (Please Print)	Father (Please Print)	Date

Mother (Signature)	Father (Signature)	Date

Four Circles Extranet

As a program participant, you can designate person(s) to view updates regarding your involvement at the program. The name of this service is the Four Circles Extranet.

Within three business days, your designated person(s) will receive an e-mail with a unique user name and password to enable them to access the Extranet. Four Circles will update your information each week.

Your designated person(s) may look at this site as often as they wish until 30 days after your completion of the program, at which time the record will be removed.

____ Yes, I would like_____(name of person) who is my_____(state relationship to yourself, ie. parent, friend, therapist) to have access to my site.

E-mail address:_____

____ Yes, I would like_____(name of person) who is my_____(state relationship to yourself, ie. parent, friend, therapist) to have access to my site.

E-mail address:_____

Additionally,
____ If Four Circles takes a picture of me and another program participant(s) from my group, you have my permission to upload that picture to the other participant(s) Extranet site.

____ No, I would not like to take advantage of the Four Circles Extranet.

_____
Printed Name

_____ _____
Signature of Program Participant Date

FOUR CIRCLES RECOVERY CENTER ENROLLMENT AGREEMENT

This agreement (“Agreement”) is entered into, by and between Four Circles Recovery Center, LLC, (hereinafter "Four Circles Recovery Center"), a Delaware limited liability company, operating a residential drug rehabilitation program, which is described in the program materials that _____ has received previously and which is made a part of this Agreement by reference (the "Program") and _____ (hereafter the "Participant").

In consideration of the mutual promises set forth in this Agreement, Four Circles Recovery Center and Participant (hereinafter the "Parties") mutually agree as follows:

1. PARTICIPANT'S REPRESENTATIONS. Participant warrants that Participant's birth date is _____ and that Participant desires to and does hereby contract with Four Circles Recovery Center for the Participant's enrollment in the Program according to the terms and conditions of this Agreement. In entering into and performing under this Agreement, Four Circles Recovery Center is relying on all representations and promises of the Participant contained or expressed in this Agreement and all other documents and information sheets from Participant to Four Circles Recovery Center, and Participant expressly warrants the truth and accuracy of same.

2. ENROLLMENT OF THE PARTICIPANT. Upon Participant's initial payment as set forth in Exhibit "A", and completion of this Agreement, the Enrollment Application and all related documentation, and upon Four Circles Recovery Center’s execution of this Agreement, shall accept the Participant conditionally for enrollment in the Program, subject to the terms and conditions of this Agreement. Participant acknowledges and agrees that Four Circles Recovery Center’s conditional acceptance of the Participant is subject to the personal evaluation and screening process conducted by Four Circles Recovery Center prior to completion of the Assessment phase of the Program. If the Participant satisfies Four Circles Recovery Center’s screening criteria, Four Circles Recovery Center shall accept the Participant and, except as otherwise provided herein, permit the Participant to complete the Program. If the Participant fails to satisfy Four Circles Recovery Center’s screening criteria, Four Circles Recovery Center will return the prepaid tuition fee to the Participant, less a $ **N/A** evaluation/screening fee and a deduction for all reasonable expenses incurred by Four Circles Recovery Center on behalf of the Participant prior to the Participant's return.

3. TERM OF AGREEMENT/CUSTODY. Assuming the Participant is accepted into the Program, the term of this Agreement shall be a minimum of 42 Days beginning with the Participant's arrival in Horse Shoe, North Carolina, as the case may be, now anticipated on _____ (the "Arrival Date").

4. PROGRAM COSTS AND PAYMENT TERMS.

A. PROGRAM FEE. The Participant is accepted with the expectation that the Participant will complete the entire Program. Unless otherwise set forth in Exhibit "A", the Program fee is $465 per day, plus professional fees.

B. SCHEDULE AND METHOD OF PAYMENT OF PROGRAM FEES; LATE FEES; EXTENSIONS.

(1) At the time of admission, private pay Participants shall pay the full initial amount of the Participant’s scheduled stay plus the enrollment fee.

(2) This initial payment may be paid by check. All subsequent payments, if any, shall be paid only by accepted credit card (VISA, MasterCard or American Express), wire transfer or pre-authorized electronic check debit (ACH).

(3) Participant shall also provide a valid credit card number with available credit at the time of admission. In the event that any fees, costs or subsequent extensions, including but not limited to the initial physical cost, medication costs, outfitting costs and additional medical expenses, are not paid when due, Participant authorizes the program to charge these items, including late fees, to this credit card number.

(4) With the exception of the discharge summary, Participant's files and records will not be released after a Participant discharges until all tuition and fees are paid in full.

(5) Participants with Participant loans must provide a copy of an executed promissory note from the lending institution at the time of admission. Actual funding must take place within five days of enrollment.

(6) Any extension must be agreed upon by staff and Participant prior to its commencement. Payment for an extension must be paid in advance for the full length of the additional stay. Failure to pay within the first week of the extended period could result in the immediate Participant's discharge.

C. EMERGENCY ADMISSION EXCEPTION. Upon written approval by the program, the Participant who is admitted within 48 hours of the initial call shall pay a deposit of a minimum of 10 days and sign an enrollment agreement. This deposit must be secured by a third party, such as a credit card, wire transfer, ACH transfer or cashier's check. Personal checks are not acceptable for deposits. Full payment for the program's minimum length of stay must be received no later than seven days of admission. If payment for the remainder of the agreed upon minimum length of stay has not been received within seven days of admission, the Participant will be discharged prior to 10 days.

D. PAYMENT/CANCELLATION REFUNDS. A cancellation received less than seven (7) days prior to the arrival date will result in a 50% refund. The amount retained by Four Circles Recovery Center may, if deemed appropriate by Four Circles Recovery Center, be used as credit against any future enrollment of the Participant.

E. EARLY WITHDRAWAL OF PARTICIPANT. If Participant withdraws before expiration of the minimum period of enrollment without the recommendations of the Program Director, an early withdrawal fee (See Exhibit A).

F. ADDITIONAL COSTS AND EXPENSES. In addition to the Program fee, Participant agrees to pay for the following expenses: transportation from the Participant's current residence to Horse Shoe, North Carolina as the case may be, and return transportation to the Participant's current residence; food and lodging expenses for any holding period before commencement of the Program and/or after completion of the Program; all medical, dental, hospital, and related expenses incurred by or for the Participant and all required personal items specified in the Participant Clothing List. Participants are also responsible for any additional escort fees required for transporting Participant to and/or from the Program to another location (i.e. airport, doctor's appointment or special event). Participants are responsible for the cost of any psychiatric evaluations performed by a psychiatrist.

G. PERSONAL INJURY AND DAMAGE TO PROPERTY. Participant agrees to accept full responsibility for (1) the repair or replacement of any property damaged, defaced, or destroyed by the Participant, whether owned, leased, or controlled by Four Circles Recovery

Center or any third party, and (2) any personal injury to any Four Circles Recovery Center personnel, other Participants or third parties caused, in whole or in part, by the Participant; and to promptly reimburse Four Circles Recovery Center for any costs and expenses, including legal fees, it may incur in connection therewith.

I. LOSS OR DAMAGE TO PARTICIPANT'S PROPERTY. Four Circles Recovery Center is not liable for any loss of or damage to any of the Participant's property. The Participant is fully responsible for the same at all times.

J. SUBCONTRACTING. Participant agrees and consents to Four Circles Recovery Center subcontracting certain services to be rendered under this Agreement to persons or entities deemed by Four Circles Recovery Center to be properly qualified to provide said services, at no additional cost to Participant unless otherwise agreed to by both parties. Four Circles Recovery Center is not responsible for the services provided by such third-party contractors and is hereby released from any liability arising from such services. All clinicians furnishing services to the Participant, including any psychiatrists, psychologists, mental health professionals, or internists or the like, are independent contractors with the client and are not employees of Four Circles Recovery Center. The Participant is under the care and supervision of his/her attending clinician and it is the responsibility of the Participant's clinician to obtain the Participant's informed consent, when required, for medical, surgical, or psychiatric treatment, special diagnostic or therapeutic procedures, or other services rendered the Participant under the general and special instructions of the clinician.

K. NURSING CARE. Four Circles Recovery Center provides only general nursing care unless, upon orders of the Participant's physician, the Participant is provided more intensive nursing care. If the Participant's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the Participant. Four Circles Recovery Center shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that Participant is not provided with such additional care.

5. ASSUMPTION OF RISKS; RELEASES AND INDEMNITIES. Participant acknowledges serious hazards and dangers, known and unknown, inherent in the Program, including but not limited to ranch, agricultural and vocational activities, emotional and physical injuries, illness or death that may arise from strenuous hiking, climbing and camping in a natural environment, exposure to the elements, plants and animals, running away from the Program, "acts of God" (nature), the ropes course, stress, involvement with other Participants, self-inflicted injuries, and transportation to and from the Program's field location(s), and agrees to assume and does knowingly and voluntarily assume all of the risks inherent in the Participant's participation in the Program and all of its related activities, and the risks associated with the Participant's unique medical, physical, mental and/or emotional limitations; and Participant acknowledges that Participant has had adequate opportunity to ask Four Circles Recovery Center any questions Participant may have about the Program and its inherent risks, and gives Participant's informed and unqualified consent thereto; and Participant agrees to fully release, hold harmless and indemnify Four Circles Recovery Center, and any and all of its officers, directors, employees, agents and subcontractors from and against any and all liabilities, claims, damages, fines, losses and expenses, including legal fees, that may arise or be incurred as a result of the Participant's participation in the Program and related activities. In addition, Participant agrees to release, indemnify and hold harmless Four Circles Recovery Center, its employees, agents and subcontractors from and against any and all liabilities, claims, damages, fines, losses

and expenses, including legal fees, that may arise or be incurred, directly or indirectly, as a result of their actions taken pursuant to the authorizations, agreements, warranties and representations set forth in this Agreement or the application forms.

6. AUTHORIZATION FOR MEDICAL CARE AND RECORDS. In the event of an accident, injury, illness, or other medical necessity, Participant hereby authorizes Four Circles Recovery Center to: (a) provide emergency first aid to the Participant in the field and enroute to any hospital or clinic, (b) arrange for any medical, dental, psychiatric, hospital, ambulance or other health-related care for the Participant deemed necessary by Four Circles Recovery Center's staff; and (c) authorize a physician, dentist or other health-care professional(s) to perform any procedure(s) that the health-care professional(s) deems necessary for the well-being of the Participant. All costs and expenses incurred for these services shall be the sole responsibility of the Participant. Participant also authorizes Four Circles Recovery Center to arrange for a physical examination (including a drug screen urine/blood test, at Four Circles Recovery Center option) and any psychological assessments of the Participant deemed necessary by Four Circles Recovery Center prior to the Participant's beginning the Program. Participant also authorizes any and all medical doctors, psychiatrists, psychologists, counselors, therapists, hospitals, clinics and treatment centers that have treated or counseled the Participant, and whose names Participant shall provide to Four Circles Recovery Center, to release all information regarding the Participant's medical and/or psychological history, diagnoses and treatments to Four Circles Recovery Center upon request. Four Circles Recovery Center shall handle all such protected health information (also "PHI") pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act ("HIPAA") of 1996.

7. AUTHORIZATION FOR SEARCH AND SEIZURE. Participant hereby acknowledges and agrees that Four Circles Recovery Center personnel may search the person and personal effects of the Participant at any time, including a "strip search." In connection with such search, Four Circles Recovery Center may, in its discretion, require Participant to remove all of his or her clothing and may search Participant's entire person. Four Circles Recovery Center is further authorized to confiscate any and all items deemed by Four Circles Recovery Center to be contraband or counterproductive to the Participant's successful completion of the Program. The disposition of all items confiscated by Four Circles Recovery Center shall be left to the sole discretion of Four Circles Recovery Center.

8. AUTHORIZATION FOR RESTRAINT. Participant hereby acknowledges and agrees that Four Circles Recovery Center personnel may physically restrain, control and detain the Participant by the exercise of necessary restraints when deemed necessary by Four Circles Recovery Center, for purposes including but not limited to preventing the Participant from jeopardizing the Participant's own safety or the safety of others.

9. RESEARCH AUTHORIZATION. Participant hereby authorizes Four Circles Recovery Center to use data from the Participant's records, tests, and assessments for purposes of ongoing research, provided that the Participant's name and identity will be kept confidential and not used in any published materials.

10. EARLY TERMINATION BY FOUR CIRCLES RECOVERY CENTER/LIQUIDATED DAMAGES. Four Circles Recovery Center reserves the right to terminate this Agreement at any time due to: (i) failure of Participant to pay any amounts due under paragraph 4; (ii) illegal, uncontrollable, or dangerous behavior by the Participant; (iii) discovery of any unprompted or previously unknown physical, medical, mental, or emotional problem(s) of the Participant; (iv) failure of Participant to abide by the terms and

conditions of Participant's enrollment, as set forth in this Agreement; or (v) for any other reason if Four Circles Recovery Center deems it necessary for the protection of the Participant, any other Participant(s) or the integrity of Four Circles Recovery Center Program. **In the event that Four Circles Recovery Center elects to terminate the Participant pursuant to the terms of this paragraph, Participant understands and agrees that Participant forfeits all monies pre-paid to the program.** The forfeiture reflects the recognition that certain costs associated with making the program available to the Participant are incurred, whether or not the program is completed, including such items as salaries, inventories, and other general operating expenses. Therefore, Participant understands and agrees that the policy of non-refundable payments and expenses is a reasonable estimate of the losses (i.e., Liquidated Damages) the program incurs with the early termination of Participant.

11. PARTICIPANT EDUCATION PROGRAM AND COOPERATION. Participant agrees to attend educational seminars conducted by Four Circles Recovery Center during the Program, if any, and to give Participant's full cooperation to Four Circles Recovery Center personnel throughout the Program, in order to maximize the benefits of the Program for the Participant. Participant also agrees to read any educational materials and watch any video programs sent to Participant by Four Circles Recovery Center, and to fill out and return to Four Circles Recovery Center any interactive educational materials, while the Participant is in the Program.

12. ESCORTS. If an escort is required to bring the Participant to North Carolina for the Program, Participant agrees that any escort or escort service used by Participant, whether or not Participant is referred to the escort by Four Circles Recovery Center, is in all respects an independent contractor contracting directly with Participant. Participant agrees that Four Circles Recovery Center bears no responsibility of any kind for any such escort service or the negligence or failure thereof.

13. HEALTH INSURANCE. Participant warrants that the Participant is presently covered, and will for the duration of the Program be covered, by adequate health insurance covering claims that may arise in connection with any accident, injury or illness that the Participant may suffer or incur during the Program. Whatever deductibles or coverage exclusions may apply in a given case shall be satisfied entirely by Participant.

14. EMANCIPATION. Participant warrants that the Participant is not a minor, both by age and as a matter of law.

15. DELAYED PERFORMANCE. Except for the obligation to make payments when due hereunder, all other obligations under this Agreement shall be suspended for so long as one or both parties hereto are prevented from performing hereunder by acts of God/nature, the elements, acts of federal, state or local governments, agencies or courts, damage to or destruction or unavoidable shut-down of necessary facilities, or other matters beyond their reasonable control; provided, however, that any party so prevented from complying with its obligations hereunder shall promptly notify the other party thereof and shall exercise due diligence to remove and overcome the cause of such inability to perform as soon as practicable.

16. BINDING ARBITRATION. Any controversy or claim arising out of or relating to this contract, except at Four Circles Recovery Center's option the collection of monies owed by Participant to Four Circles Recovery Center, shall be settled by binding arbitration conducted in the State of California, County of Los Angeles, in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction for purposes of executing upon the award.

17. ATTORNEY'S FEES. In the event that either party is found in default or material breach of any specific promise, term or condition expressly set forth in this Agreement by an arbitrator(s) or a court of competent jurisdiction, said party shall be liable to pay all reasonable attorneys' fee, court costs and other related collection costs and expenses incurred by the other party in enforcing its contractual rights hereunder in said arbitration and/or court proceeding(s). In addition, Participant agrees to compensate Four Circles Recovery Center for all reasonable attorneys' fees and costs incurred by Four Circles Recovery Center in connection with those matters concerning which Participant has agreed to pay or indemnify Four Circles Recovery Center herein.

18. NOTICES. Any and all notices, payments, reports and other correspondence required hereunder shall be deemed to have been properly given or delivered when made in writing and delivered personally to the party to whom directed, or when sent by United States mail with all necessary postage or charges fully prepaid, and addressed to the party to whom directed at its below specified address (or a new address after written notice of such change is given to the other party).

Four Circles Recovery Center
c/o Aspen Education Group
17777 Center Court Drive, #300
Cerritos, CA 90703

Participants' Name _____
Address _____
City, State, Zip _____

19. AMENDMENTS. This agreement may be amended at any time upon mutual agreement of the parties hereto, but any amendment(s) must first be reduced to writing and signed by both parties in order to become effective.

20. WAIVER. A waiver by any party of any provision hereof, whether in writing or by course of conduct or otherwise, shall be valid only in the instance for which it is given, and shall not be deemed a continuing waiver of said provision, nor shall it be construed as a waiver of any other provision hereof.

21. PARAGRAPH HEADING. The paragraph headings of this Agreement are inserted only for convenience and in no way define, limit or describe the scope or intent of this Agreement nor affect its terms and provisions.

22. GOVERNING LAW/VENUE. This Agreement, and all matters relating hereto, including any matter or dispute arising between the parties out of this Agreement, tort or otherwise, shall be interpreted, governed, and enforced according to the laws of the State of California; and the Parties consent and submit to the exclusive jurisdiction and venue of the California Courts in Los Angeles County, California, and any qualified (American Arbitration Association-approved) arbitration service in the State of California, County of Los Angeles, to enforce this Agreement. The parties acknowledge that this agreement constitutes a business transaction within the State of California.

23. SEVERABILITY. In the event that any provision of this Agreement, or any operation contemplated hereunder, is found by a court of competent jurisdiction to be inconsistent with or contrary to any law, ordinance, or regulation, the latter shall be deemed to control and the Agreement shall be regarded as modified accordingly and, in any event, the remainder of this Agreement shall continue in full force and effect.

24. NUMBER. As used in this Agreement, singular pronouns shall include the plural and plural pronouns shall include the singular, whenever the context so requires.

25. ACKNOWLEDGEMENT/ENTIRE AGREEMENT. Participant hereby acknowledges that Participant has read this Agreement and that Participant understands and consents to all of its provisions; that this Agreement together with the Application Form and any additional releases signed by Participant constitutes the entire agreement between the parties hereto with respect to the subject matter hereof; and that all other prior agreements, promises, expectations and conditions, oral or written, between the parties are incorporated herein. Other than the express commitments set forth in this Agreement and the Program description, Four Circles Recovery Center gives no warranties of any kind, express or implied, to Participant concerning the Program; and Participant acknowledges that Participant is not relying on any warranties or representations of any kind other than the express commitments of Four Circles Recovery Center sets forth herein.

26. BINDING EFFECT. This Agreement shall be binding upon and inure to the benefit of the parties hereto, their heirs, personal representatives, successors and assigns.

27. RELEASE OF INFORMATION. The parties authorize the release of the Participant's information via E-mail, Internet technology, voice mail or US mail. While every effort will be made to maintain confidentiality, Four Circles Recovery Center accepts no responsibility for the mistransmission that could result in information becoming available to someone other than the intended receiver. Four Circles Recovery Center shall handle all such protected health information (also "PHI") pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act ("HIPAA") of 1996 as well as 42 CFR Part 2.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the dates set forth below.

_____ Date: _____
Participant Name (Print)

_____
Signature

Accepted:
FOUR CIRCLES RECOVERY CENTER, LLC

By_____ Date: _____
Name, Title (Print)

_____
Signature

EXHIBIT A- Enrollment Agreement

I/Sponsor(s) understand that the cost of Four Circles Recovery Center is $465.00 per day and a $2,000.00 enrollment fee. I/Sponsor(s) understand that there is a minimum initial payment of **$15,020, due upon admission,** which covers the first 28 days of the program. I/Sponsor(s) further understand that if participant remains enrolled in the program beyond the initially indicated length of stay that **ALL EXTENSIONS ARE BILLED AT A DAILY RATE OF $465.00 PER DAY, AND ALL EXTENSIONS ARE BILLED TO A CREDIT CARD. If participant withdraws from the program before the expiration of the period of enrollment without the recommendation of the Program Manager, an early withdrawal fee of $5,000 plus the enrollment fee plus the accrued daily rate $465.00 will be retained.**

*****INCIDENTAL EXPENSES DEPOSIT*****

Please include a credit card number below as all extensions and incidental expenses will be charged to this Credit Card.

Credit Card Information for extensions and incidental expenses

Visa/MasterCard/American Express/Discover/Diners:
_____CVV #_____ Exp: _____

Name on the Credit Card: _____
Card Billing Address: _____
_____

Authorized signature: _____ Date: _____

Please indicate method of payment for program:

☐ **Credit Card**
Visa/MasterCard/American Express/Discover/Diners:
_____ CVV #: _____ Exp:_____

Card Billing Address: _____
_____

Authorized signature: _____ Date:_____

☐ **Check payable to Four Circles Recovery Center**
Send payment to: Four Circles Recovery Center, 156 Clear Crossing Lane, Horse Shoe, NC 28742

☐ **Wire Transfer** (**PLEASE HAVE BANK FAX THE TRANSFER FORM TO 828-891-2224)**
*Please call for Wire Instructions

☐ **Clark Custom Educational Loan**

1. My signature below is a formal application to participate with Four Circles Recovery Center and an understanding of its physical demands.
2. I release Four Circles Recovery Center, its employees, and contractors from any and all liability resulting from our my participation and assume all risks therewith, including known and unknown risks.
3. I understand that even though the program works extremely well, results are not and cannot be guaranteed.
4. **Four Circles Recovery Center charges for the length of stay participant remains in our program. Any unused portion of the fee will be refunded in accordance with refund policy stated above.**
5. Please note, until we have received your complete application and/or any testing, we cannot assure a space for the week requested.
6. Payment must be received prior to course starting date.

Participant's Name _____ Date: _____

Sponsor(s) Signature: _____ Date: _____

Sponsor(s) Name: _____ Date: _____

OPTIONAL PSYCHOLOGICAL TESTING

A comprehensive battery of psychological testing is available as an optional service at Four Circle Recovery Center (FCRC). All psychological testing is conducted by doctoral level psychologists, who are contracted through the Center for Research, Assessment, and Treatment Efficacy (CReATE) in Asheville, NC. All testing will occur on site at FCRC.

Psychological testing is a comprehensive evaluation procedure that measures and identifies important information about an individual's current level of functioning, mental health conditions or emerging psychopathology, underlying cognitive or learning issues, strengths and weaknesses, identification of risk factors, and recommendations for maximizing success in treatment and subsequent to placement at FCRC. The evaluation can assist in clarifying diagnoses and formulating a successful treatment plan through improved understanding of the complex interplay between emotional, behavioral, cognitive, personality, and learning issues.

Consent for Psychological Testing

I hereby agree to complete psychological testing. I understand that the psychologists of CReATE will honor my confidentiality agreement and will only disclose information to those for whom I have signed consent forms and my therapist at FCRC. I understand that all test protocols and all materials generated from the assessment are the property of CReATE. FCRC has my permission to release information about me to the psychologist who is conducting the evaluation. I understand that the psychologist will keep all information confidential and will not share the information with anyone else, or any other agency, without my written consent. I understand that the testing will occur at FCRC and that the psychologist will return to FCRC to go over the testing results with me.

☐ **Yes, please complete psychological testing at an additional cost of $ 2470.00**

The cost of testing will be paid by the following:

Name of Financially Responsible Party _____

☐ **Payment by Credit Card** (Visa, MasterCard, or American Express)

Credit Card Number:_____CVV Number _____Exp Date:_____

Name Exactly As It Appears on the Card_____

☐ **Cashiers Check** (payable to: Four Circles Recovery Center)

Tracking number must be provided_____

Name of Person to be tested_____Date:_____

Signature of Person to be tested_____Date:_____

Signature of financially responsible party:_____ Date:_____

☐ **No, I do not wish to have testing conducted at this time.**

Signature:_____ Date:_____

DEAR INSURANCE PROVIDER:

- ☑ **WHAT FCRC IS –** Four Circles Recovery Center is licensed in the state of North Carolina as a ***Day Treatment for SA (substance abuse)***, mental health facility (license number MHL-045-063).

- ☑ **WHAT FCRC IS NOT –** Four Circles Recovery Center is not a hospital or residential treatment program.

- ☑ **SERVICES BREAKDOWN –** Four Circles Recovery Center can provide an itemized receipt to clients at the end of their stay. This receipt breaks down the cost of the program day by day and includes dates of service as well as codes used for the processing of insurance claims.

- ☑ **DIAGNOSIS CODES –** The primary and secondary diagnosis codes listed at the top of the service breakdown are ICD-9-CM codes from the DSM-IV-TR.

- ☑ **SERVICE CODES –** The appropriate service codes are listed throughout the breakdown. An explanation for each code listed is at the end of the breakdown after the total program amount. Please keep in mind that FCRC is not a hospital; therefore, the service code for room and board is not for a hospital stay. Also, there are no service codes for miscellaneous costs.

- ☑ **MISCELLANEOUS COSTS** - The miscellaneous costs cover a 24-hour on call service. A primary responder, primary therapist and primary administrator are always on call in case of emergency.

- ☑ **THERAPIST CREDENTIALS –** Each client is assigned a primary therapist who directly administers psychotherapy to that client for the length of his or her stay. This therapist's name and credentials appear at the top of the breakdown under the client name and other information.

- ☑ **CLAIMS –** Four Circles Recovery Center is NOT responsible for submitting claims and does not participate with any insurance providers. It is the client responsibility to submit a claim for coverage.

- ☑ **QUESTIONS –** If any questions arise during the processing of a claim that the client cannot answer, please call the Four Circles Recovery Center main office at (828) 891-2221.

FREQUENTLY ASKED QUESTIONS

WHO FILES THE INSURANCE CLAIMS?

Either the client and/or the parents of the client will file the necessary paperwork into the insurance company. Throughout the filing process, insurance companies may request specific information from FCRC. When such information is needed, please contact our main office so that we can assist you with the request.

HOW IS INSURANCE HANDLED?

If you plan to file a claim with your insurance company for the client's stay at Four Circles Recovery Center:

1. Acquire and complete the appropriate claim forms that your insurance company requires for the reimbursement process.
2. FCRC can and will provide a cost breakdown sheet that includes dates of service, diagnosis codes, service codes, types of services, tax identification number, therapist name and therapist credentials. ***PLEASE NOTE***: The cost breakdown sheet will be provided at the ***END*** of the client's stay at FCRC (***It can be distributed on the day of graduation or mailed to the client and/or parents shortly after a client leaves FCRC)***
3. FCRC does not participate with any insurance companies, which means we do not supply or fill out claim forms (UB-92s, etc).
4. Again, we will be happy to provide your insurance company with further information about our program and the client's stay here in order to facilitate your claim.

IS MY STAY *(OR MY CHILD'S STAY)* AT FCRC TAX DEDUCTIBLE?

Some clients/parents have reported the FCRC Breakdown on their tax return as a medical expense. However, we at FCRC are not qualified to answer tax-related questions. Such questions should be directed to your personal accountant or tax preparer.

Four Circles Recovery Center

Nicotine Patch Policy

Four Circles Recovery Center is a tobacco-free program. As an approved substitute, clients are allowed to bring with them nicotine patches.

To assure that clients who choose to use nicotine patches are always fully supplied, we ask that they arrive at Four Circles with a two week supply. From then on, any needed patches will be purchased by our medical staff using the credit card supplied on the Nicotine Patch Policy Form. We have found this to be the best method to avoid any delays due to mailing.

We ask that all clients that are physically addicted to nicotine come to our program with the dosage of patches that best correlate to their weight and level of addiction. Our medical staff will work with each client in following carefully the tapering down of dosages during their course of stay with Four Circles.

Nicotine Patch Form

We require that you submit a credit card number to cover the expense of nicotine patch purchases.

I authorize Four Circles Recovery Center to use my credit card for the purchase of nicotine patches for the duration of the program.

Credit Card Number

Credit Card Type: _____ Exp Date: _____ CVV# _____

Authorized Signature: _____ Date: _____