PATH
Behavioral Healthcare

1370 S. West Temple
Salt Lake City, UT 84115

REGISTRATION FORM

Client Information:

Today's Date: _____

Full Name: _____ Preferred Name: _____

Address: _____ City _____ State_____ Zip _____

Home Phone: _____text/call (circle one) Cell Phone: _____ text/call (circle one)

Email Address:_____

Client Sex: Male/Female/Other_____ (circle one) Preferred Pronouns:_____ Race:_____

Client Birth Date: _____ Social Security Number: _____

Legal Guardian's Name/Relation: _____

Last School Attended: _____

Secondary Contact Name/Relation: _____

(By signing this document PATH is permitted to contact this person if client/guardian cannot be reached)

Phone Number: _____

Email:_____

Is Client currently involved with any other service providers? Yes/no (circle one)

If yes – Provider Name:_____

Provider Agency:_____

Provider Phone Number:_____

Does Client have active Medicaid coverage: Yes/no (circle one)

Name of Insurance Company:_____

Insurance/Medicaid Member ID:_____ Group Number:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Brief Description of Presenting Problem/Reason for Referral:

_____

_____

_____

_____

_____

_____

_____

Who referred you to PATH?

_____

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NOTICE OF PRIVACY PRACTICES

Client Name:_____ Client DOB:_____

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

1. You have the right to receive a paper copy of the Notice and/or an electronic copy by email upon request. PATH Behavioral Healthcare has the right to review this Notice and if revisions are made to this notice you have the right to receive the revised copy.
2. You have the right to file a complaint with PATH, if you think we may have violated your privacy rights, or if you disagree with a decision, we made about access to your Protected Health Information (PHI). You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington D.C., 20201 or call 1-877-696-6775. There will not be any penalties against you if you make a complaint.
3. PATH Behavioral Healthcare is required to maintain the privacy of the information in your file, and to abide by the terms of this notice.
4. Your Protected Health Information (PHI) refers to individually identifiable information relating to the past, present, or future physical or mental health or condition of you the client, provision of health care to you, or the past, present, or future payment for health care provided to you.
5. PATH Integrated Healthcare maintains a limited right to use and/or disclose your PHI for purposes of treatment, payment, and health care operations as follows:

- For Treatment
  - We may use medical information about you to provide you with behavioral health and medical treatment or services. We may disclose medical information about you to doctors, nurses, counselors, healthcare professionals in training, or other agency personnel who are involved in taking care of you through the agency. For example, a medical diagnosis may be shared with a specialist to help in your treatment process. Different departments of the agency may also share medical information about you to coordinate the different things you need, such as prescriptions, counseling, and residential support.
- For Payment
  - We may use and disclose medical information about you so that the treatment and services you receive at the agency may be billed to and payment may be collected from you, an insurance company or a third party. For example, we need to give the Ohio Medicaid/ADAM HS Board and/or the State Departments information about counseling you received at the agency so the Board will pay us for the services.
- For Healthcare Operations
  - We may use and disclose medical information about you for agency operations. These uses and disclosures are necessary to run the agency and make sure that all of our clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many agency clients to decide what additional services the agency should offer, what services are not needed and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health professionals in training, and other agency personnel for review and learning purposes. We may also combine the medical information we have with medical information from other agencies to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning who the specific clients are.

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1370 S. West Temple
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NOTICE OF PRIVACY PRACTICES (CONT.)

6. PATH Behavioral Healthcare maintains a right or is required by law to use and/or disclose your PHI in certain circumstances without your authorization. Refer to PATH Behavioral Healthcare HIPPA Policies and Procedures manual for specific explanations regarding these cases. The following circumstances do not require your authorization: to employers (for medical surveillance activities); concerning victims of abuse, neglect, or domestic violence; to health oversight agencies; for judicial/administrative proceedings; for law enforcement purposes; for approved research; to correctional institutes; to avert a serious threat to health or safety; for workers compensation purposes; and relating to decedents.
7. You have the right to revoke your authorization at any time to stop future uses and/or disclosures expect to the extent that PATH Behavioral Healthcare has already undertaken an action in reliance upon your authorization.
8. PATH Behavioral Healthcare may send appointment reminders and other similar materials to your home unless you provide us with alternative instructions.
9. PATH Behavioral Healthcare may contact you about treatment alternatives or other health related benefits and services.
10. You have the right to request the receipt of confidential communications by alternative means or at alternative locations as long as it is reasonably easy for PATH Behavioral Healthcare to do so.
11. If PATH Behavioral Healthcare informs you about the disclosure in advance and you do not object, Path Behavioral Healthcare may share with your family, friends, or others involved in your care, information directly related to their involvement in your care, or payment for your care, PATH Behavioral Healthcare may also share PHI with these people to notify them about your location, general condition, or death.
12. You have the right to request restrictions on uses and disclosures of information in your file. PATH Behavioral Healthcare is not required to agree to requested restrictions.
13. You have the right to receive confidential communications of PHI, and you also have the right to inspect, copy, and amend your PHI as permitted under the regulations of HIPPA
14. You have the right to receive a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure; for treatment, payment, and operations; to your, your family, or the facility Director; or pursuant to your written authorization. The list will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 14, 2003. PATH Behavioral Healthcare will respond to your written request for such a list within 60 day s of receiving it. Your request can relate to disclosures going as far back as 7 years.
15. You may complain to Path Behavioral Healthcare and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

PATH
Behavioral Healthcare

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NOTICE OF PRIVACY PRACTICES (CONT.)

SUBSTANCE ABUSE ONLY

1. The Confidentiality of Protected Health Information (PHI) related to alcohol and/or drug abuse is protected by Federal law, 42 CFR 2 and regulations. Violations of the applicable Federal law and regulations are a crime and may be reported to appropriate authorities.
2. We may not disclose any information about your unless you authorize the disclosure in writing, except as specified below.
3. We may disclose information about you if a court orders the disclosure
4. We may disclose information about you in a medical emergency, to permit you to receive needed treatment.
5. We may disclose information about you for purposes of program evaluation, audits, or research.
6. We may disclose information if you commit a crime on our premises or against any person employed with us, or it you threaten to commit such a crime.
7. We are required to disclose information about you if we suspect child abuse or neglect.
8. Except as stated in this notice, you have the same rights and protections with respect to your health information as described in our general Notice of Privacy Practices.

I have read, understand, and have received a copy of the Notice of Privacy Practices Form.

_____ _____

Client or Parent/Guardian Signature (if client underage of 18) Date

_____ _____

PATH Staff Signature Date

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UTAH – PATH Behavioral Health
Summary of Client Financial Responsibility

Client Name: _____ DOB:_____
Guarantor Name:_____ DOB:_____

Self-Pay Agreement/Waiver

☐ I acknowledge that I will be solely responsible for services rendered here at PATH Behavioral Health. I agree to pre-pay PATH Behavioral Health, the full and entire amount of treatment prior to each service given to me or to the above named patient at each visit

☐ I have Medicaid, however, should my benefits lapse or be terminated, I understand that I will automatically be moved to Self-Pay. I agree to communicate with PATH staff if this occurs, especially if I am reapplying for Medicaid.

☐ I have health insurance; however, I chose not to utilize my health care benefits. I understand that I will automatically be Self-Pay and agree to pay the rates on this form for each visit.

Client/Guarantor Signature: _____ Date:_____

PATH Behavioral Health appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our stated fees. This form provides information about our fee schedule. You are responsible for payment of your bill prior to each service and a breakdown of that responsibility can be found below. We do utilize Medicaid's rates for the self-pay rates. We do not mark up any charges. You will only be billed for the time you select and prepay for. We will give you a paid receipt so you can submit to your commercial insurance company, if applicable. Any questions please contact the billing department at: billing@pathihc.com

PATH Model for Client Fees

PATH Behavioral Health subscribes to a model oof therapy that recommends clients participate in the least amount of sessions needed to stabilize their current symptomology, identify the core issues that contributed to their initial or ongoing distress, identify primary client strengths and resources that they can utilize to move forward in a positive manner, formulate an individualized plan for each client, and assist clients in developing the necessary skills to address these issues independently and without ongoing clinical intervention.

Summary of Ongoing Charges

I have read the above policy regarding my financial responsibility to PATH Integrated Health for providing services to me or the above named client. I acknowledge that this only represents currently planned services and that additional services may be offered based upon clinical recommendation. PATH Integrated Health will notify me and gain approval prior to offering any additional services. I certify that the information is, to the best of my knowledge, true and accurate.

Client/Guarantor Signature:_____ Date_____

SERVICE FEES

Initial Services
Assessment Services CPT Code 90791 (60-90 min), PATH rate: $111.11
Ongoing Services
Individual Therapy: CPT Code 90834 (38-52 min), PATH rate: $78.82
Family Therapy with or without child present CPT Code 90846/90847 (50 min), PATH rate: $132.82
Group Therapy per Session CPT Code H2019 (90 min), PATH rate: $41.82
Case Management-CPST, CPT H0036 (23-37 min), PATH rate: $39.08
MedSom: Dr/NP Visit – New Patient 60 mins CPT Code 99205, PATH rate: $138.46
Dr/NP Visit – Established Patient 30-39 mins CPT Code 99214, PATH rate: $65.03
Dr/NP Visit – Established Patient 40-49 mins CPT Code 99215, PATH rate: $91.58

PATH
Behavioral Healthcare

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TELEHEALTH INFORMED CONSENT FORM

Client: _____ Client DOB:_____

Effective Date: _____ Expiration Date: _____

I, _____ consent to engage in telehealth with PATH Behavioral Health as part if the therapy process and my treatment goals. I understand that telehealth behavioral health services may include mental health evaluation, assessment, consultation, treatment, planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone, and/or other audio/video communications. I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. I understand that the information released by me during my sessions is generally confidential. There are exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the sharing of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
3. I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of PATH Behavioral Health that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

In addition, I understand that telehealth-based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to behavioral health providers who can provide those services in my area. I also understand that there are potential risks and benefits associated with any from of mental or behavioral health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to worsen.

1. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed any concerns with my therapist, and all my questions regarding the above matters have been answered to my approval. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with these communication systems. Signing this form shows an awareness of these issues and a decision by me to use these systems for telehealth services. I will not hold PATH Integrated Health or its staff liable for issues with this system beyond their control.
2. I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed any concerns with my therapist, and all my questions regarding the above matters have been answered to my approval.
3. By signing this consent, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed any concerns with my therapist, and all my questions regarding the above matters have been answered to my approval. By signing this document, I understand that emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled psychotic systems, if I am in a life threatening or emergency, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Lifeline at 1-800-273-8255.

_____ _____

Client or Parent/Guardian Signature (if client underage 18) Date

_____ _____

PATH Staff Signature Date

PATH
Behavioral Healthcare

1370 S. West Temple
Salt Lake City, UT 84115

CONSENT FOR TREATMENT

Client: _____ Client DOB:_____

Description of Treatment Services and Expectations

I understand that my family and I will be receiving services as a client of PATH Behavioral Health. I understand that the time will be set between the staff and me. As a PATH Behavioral Health client, I commit to improve my behavior and to develop a responsible, health lifestyle. I agree, at a minimum, to the following:

- Giving the program a chance to help me
- Actively participating in treatment
- Following through on referrals
- Working on my education/vocational plan
- Maintaining confidentiality of others clients
- Authorization for staff to transport myself or my family
- Recreational outings
- Vocational outings
- Following all program guidelines
- Maintaining recommended contact with treatment team
- Developing a crisis/safety plan
- Treating all staff and clients with respect
- Refraining from all aggressive, harmful, and illegal behaviors
- Following all probation guidelines (if applicable)
- Other activities as indicated in my child's treatment plan

PATH Behavioral Health's services include assessment; mental health and alcohol and drug services including therapy and/or case management, nursing, medication management services; assistance with treatment goals; development of daily living and life skills; collaboration with referral sources and other service providers; and referrals to community supports. These services are designed to help me achieve my goals and develop a healthy, responsible lifestyle.

Benefits of Program Participation: may include improved functioning in home, school, and community, as well as therapy for at risk youth, prevention of the disruption of placement, while promoting the least restrictive level of care, as well as youth who are transitioning from a residential setting or foster care to a natural family. PATH Integrated Health services are tailored to meet the needs of individuals and families.

It has been explained to me that I am a full partner in the development of mine or my family's/individual Service Plan and that I will be participating in all team meetings. I understand that I can maintain my status in the program by participating in the offered services.

PATH
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CONSENT FOR TREATMENT (CONT.)

Drug and Alcohol Services

42 CFR if a federal law that describes special confidentially rules related to drug and alcohol treatment services. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless the further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Client signature (if age 14 years or above) Date

_____

Please Print Name of Client or Guardian

_____ _____

Parent/Guardian Signature (if applicable) Date

_____ _____

PATH Staff Signature Date

PATH
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Authorization to Use and Release Protected Health Information

Situations that Do Not Require a Signed Release:

Your records or information regarding you and or family may not be released to any other individual or agency without your written consent. Certain information, however, may be released without your authorization under the following legal circumstances.

1. The receipt of a legitimate subpoena or court order.
2. In the event of a medical emergency.
3. The receipt of information that suggests that child elder abuse or neglect has occurred.
4. If the worker believes that a member of the family is a danger to himself/herself or is a danger to others.
5. Other circumstances as required/permitted by law.

Client/Guardian AUTHORIZATION

I, the undersigned, hereby authorize PATH Behavioral Health to use and/or disclose information from my (or give relationship) _____ medical record as specified above. This authorization includes use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS related conditions, any drug and alcohol abuse, drug related conditions, alcoholism and/or psychiatric/psychological conditions to the above mentioned identities.

I understand that I may inspect and have a copy of the health information described in this authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations.

I affirm that everything in this form has been explained and I believe I have a clear understanding of what my authorization means. I understand that I may receive a copy of this completed form upon request.

_____ _____

Signature of Guardian (if client underage 18) Date

_____ _____

Signature of Client (required for AoD regardless of age) Date

Path Behavioral Health Witness

I, a PATH Behavioral Health employee, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

PATH Staff Signature Date

42 CFR: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless the further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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CLIENT RIGHTS AND GRIEVANCE PROCEDURE (OAC 5112-26-18)

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy;
2. The right to reasonable protection from physical, sexual or emotional abuse, neglect, humiliation, and inhumane treatment;
3. The right to receive services in the least restrictive, feasible environment;
4. The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;
5. The right to give informed consent to or to refuse any service, treatment or therapy, including medication absent an emergency;
6. The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;
7. The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;
8. The right to be informed and the right to refuse any unusual or hazardous treatment procedures;
9. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;
10. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;
11. The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;
12. The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;
13. The right to be informed of the reason for denial of a service;
14. The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;
15. The right to know the cost of services;
16. The right to be verbally informed of all client rights, and to receive a written copy upon request;
17. The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;
18. The right to file a grievance;
19. The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;
20. The right to be informed of one's own condition; and,
21. The right to consult with an independent treatment specialist or legal counsel at one's own expense.

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CLIENT RIGHTS AND GRIEVANCE PROCEDURE (CONT)

CLIENT GRIEVANCE PROCEDURE:

1. Consumer completes Grievance form provided by employee or through PATHIHC.COM and submits to the Operations Team. The Operations Team has 10 business days to investigate and respond in writing.
2. The Operations Team will attempt to resolve the issue. If The Operations Team resolution does not satisfactorily resolve the issue, the decision can be appealed in writing to the Clinical/Regional Director. The consumer is responsible for ensuring that the appeal is received by the Clinical/Regional Director within 10 business days of the Operations Team response. The Clinical/Regional Director is to receive a copy of the original grievance form completed and signed by the person served. The Clinical/Regional Director has 10 business days to respond in writing.
3. If the person served is dissatisfied the Clinical/Regional Director's decision a final appeal may be made to the CEO by submitting the grievance to the CEO. The Committee will hear the issue at the next regularly scheduled meeting.
    a. A person served filing a grievance against the Clinical/Regional Director may appeal to The Operations Team. The timeframes in Step One will apply.
    b. The person served has the right to contact respective licensing boards, and CARF at (888) 281-6531.
    c. Final decisions on grievances are not precedent setting or binding on future grievances unless they are officially stated as Company policy.
    d. The agency will not allow any retaliation against any person who files a grievance.
    e. An annual summary of grievances will be submitted by the Management Team to the CEO for determination of:
        i. trends, areas needing performance improvement, and actions to be taken.

I, the undersigned, hereby confirm that I have carefully reviewed and comprehended Path Behavioral Healthcare's policy concerning my rights and the grievance procedure. I am fully aware that the employees of Path Behavioral Healthcare are obligated to honor and uphold my rights diligently. Additionally, I am aware that I retain the right to request a copy of my rights and the Path Behavioral Healthcare grievance procedure at any given time.

_____ _____

Signature Date

PATH
Behavioral Healthcare

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Electronic Communication Policy for Teen Day Treatment Program

The Adolescent Day Treatment Program (ADTP) at PATH Behavioral Health offers the option of communicating with staff and other participants via text messages using the office cell phone. This option is intended to provide convenience, accessibility, and support for parents and teens who are enrolled in the program. However, there are some risks and limitations associated with electronic communication that you should be aware of before consenting to this option.

Risks and Limitations of Electronic Communication

- Text messages are not a secure or confidential form of communication. They can be intercepted, hacked, forwarded, or accessed by unauthorized parties. PATH Behavioral Health cannot guarantee the privacy or security of any information that you or your teen send or receive via text messages.
- Text messages are not a substitute for face-to-face or phone communication with your therapist or other staff members. They are not appropriate for urgent or emergency situations, complex or sensitive issues, or crisis intervention. If you or your teen need immediate assistance, please call 911, 988 or go to the nearest emergency room.
- Text messages may not be received or responded to in a timely manner. PATH Behavioral Health staff may not be available to read or reply to your text messages at all times. There may be delays, errors, or misunderstandings in the transmission or interpretation of text messages. PATH Behavioral Health is not responsible for any harm or damage that may result from these factors.
- Text messages may become part of your or your teen's clinical record at PATH Behavioral Health. They may be subject to disclosure to third parties, such as insurance companies, courts, or other agencies, as required by law or professional standards.

Consent and Guidelines for Electronic Communication

By consenting to this option, you agree to the following guidelines for electronic communication with PATH Behavioral Health staff and other ADTP participants:

- You will provide PATH Behavioral Health with your current cell phone number and notify us of any changes.
- You will use text messages only for non-confidential and non-urgent matters, such as scheduling appointments, confirming attendance, requesting information, or providing feedback.
- You will limit the length and frequency of your text messages to what is necessary and appropriate for the purpose of communication.
- You will respect the privacy and confidentiality of other ADTP participants and PATH Behavioral Health staff. You will not share, forward, or disclose any text messages that contain personal or sensitive information without their consent.
- You will be courteous and respectful in your text messages. You will not use abusive, offensive, or inappropriate language or content.

PATH
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Electronic Communication Policy for Teen Day Treatment Program (Cont)

- You will follow the instructions and directions of PATH Behavioral Health staff regarding electronic communication. You will stop texting if asked to do so by PATH Behavioral Health staff.
- You will inform PATH Behavioral Health staff if you have any concerns, complaints, or problems with electronic communication.
- By consenting to this option, you also acknowledge and agree that:
- You have read and understood this policy and its risks and limitations.
- You have discussed this option with your therapist and/or other PATH Behavioral Health staff and have had the opportunity to ask questions and clarify any doubts.
- You have the right to withdraw your consent at any time by notifying PATH Behavioral Health in writing.
- Your consent applies to both you and your teen who is enrolled in the ADTP.
- Your consent is voluntary and does not affect your or your teen's eligibility or participation in the ADTP.

_____ _____

Client or Parent/Guardian Signature Date

_____ _____

Signature Date

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Acknowledgement of Educational Responsibility

PATH Behavioral Health Adolescent Day Treatment Center does not assume responsibility for our client's educational needs. This responsibility stays in the hands of the client, their parents and/or guardians. By enrolling in the program, you acknowledge the following:

- The Adolescent Day Treatment Program provides time given to clients to work on school materials along with direct tutoring support.
- The Adolescent Day Treatment Program offers no further direct education services.
- Attending the Adolescent Day Treatment Program does not qualify for any educational credits.
- The Adolescent Day Treatment Center is not responsible for registering or enrolling clients in educational programs or schools.
- Clients must be enrolled in either an educational online program or must be enrolled in school.

If you are struggling to get your child registered with an educational program or school the Adolescent Day Treatment Center can ASSIST you in registering for the online programs

Time4Learning (ages 12-15) or Canyons Virtual High School (ages 15-17).
By signing this document I acknowledge that the personal responsibility of the client's education falls to the client/guardian.

_____ _____

Client or Parent/Guardian Signature Date