Outpatient/IOP Admission Packet

TABLE OF CONTENTS/CHECK OFF SHEET

SIGNATURES NEEDED: *(OPI Office-- forms with □ must be signed)*

Participant	Parent Sponsor (if child under 18)	Check Off
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		□ General Information
		□ Family Information-Parents
		□ Family Information-Siblings
		□ Family Questionnaire
		□ Educational Information
		□ Treatment History
		□ Medical History
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	□ Physicians Signature	□ Physical Exam
□	□	□ Enrollment Agreement
□		□ OPI Rules and Precepts
□	□	□ Authorization to Release Info to OPI
□	□	□ Authorization for OPI to Release Info
□	□	□ Activities Release
□	□	□ Release of Liability
□	□	□ Complete Release of Liability – Off Premises
		□ Notice of Privacy Practices
□	□	□ Letter of Agreement Regarding the Provision of Individual Psychiatric Consultative Services
□	□	□ Letter of Agreement Regarding the Provisions of Individual Psychotherapy Services
□		□ Cancellation/No Show Policy
□	□	□ Statement of Authenticity

CREDIT CARD AUTHORIZATION

I hereby authorize **Optimum Performance Institute** to charge the indicated credit card(s) for:

____

____

Number of Credit Cards you are using: ________

PRIMARY CREDIT CARD (*circle one*): Master Card / Visa / Amex / Discover

Amount Authorized: **$**________________

Credit Card Number: _______ _______ _______ _______

Expiration Date on Card _____ /______ Security Code *(on reverse of card)*: ________

Name exactly as it appears on credit card: ____

Billing Address: ____

____ Zip _________________________

SECONDARY CREDIT CARD (*circle one*): Master Card / Visa /Amex / Discover

Amount Authorized: **$**________________

Credit Card Number: _______ _______ _______ _______

Expiration Date on Card _____ /______ Security Code *(on reverse of card)*: ________

Name exactly as it appears on credit card: ____

Billing Address: ____

____ Zip _________________________

Signed ____Date __________________________

GENERAL INFORMATION

Please take the time to complete each section thoroughly and accurately.

Date: ____________________________ Male: _______ Female: _______

Participant Name: ____

Address: ____

City, State, Zip: ____

Phone Numbers: ________________________ home ___________________________ work

________________________ Cell ___________________________ e-mail

Date of Birth: ______________________ Age: __________

Emergency Contact (if under 18, please provide parent/guardian information):

____

Address: ____

City, State, Zip: ____

Phone Numbers: ________________________ home ___________________________ work

________________________ Fax ___________________________ other

Name of Person completing this form (Printed Name): ____________________________________

Signature of person completing this form: ____

FAMILY INFORMATION - Parent Identification

Mother's Name:	Stepmother's Name
Address:	Address:
City, State, Zip:	City State, Zip:
Home Phone:	Home Phone:
Cell Phone / Email:	Cell Phone / Email:
Business Address:	Business Address:
City, State, Zip:	City, State, Zip:
Work Phone:	Work Phone:
Occupation/Title:	Occupation/Title:
Education:	Education:
Divorce Date:	Divorce Date:
Deceased:	Deceased:
Father's Name:	Stepfather's Name
Address:	Address:
City, State, Zip:	City State, Zip:
Home Phone:	Home Phone:
Cell Phone / Email:	Cell Phone / Email:
Business Address:	Business Address:
City, State, Zip:	City, State, Zip:
Work Phone:	Work Phone:
Occupation/Title:	Occupation/Title:
Education:	Education:
Divorce Date:	Divorce Date:
Deceased:	Deceased:

FAMILY INFORMATION
Sibling Identification

Please list all siblings in chronological order (eldest first). Include the applicant and all step and half siblings. Please indicate if deceased.

Name	Age	Sex	Birth Date	Deceased?

____

Family History: Please include significant medical problems, psychiatric, and/or substance abuse issues of extended family, including grandparents, uncles, aunts, and cousins.

____

____

____

____

____

____

____

____

FAMILY QUESTIONNAIRE

Neonatal History: Birthplace______________________ Birth weight______________________

Pregnancy: Normal ☐ Complications ☐ Please explain:

Neonatal Health: Normal ☐ Abnormal ☐ Please explain:

Complications:

Parental attitude regarding pregnancy/birth/adoption:

History of drug/alcohol use and/or emotional problems during pregnancy:

Adoption ☐

Circumstances of adoption (include age, birth parent history, placements):

Developmental History:

Age walking _______ Age talking in sentences______ Age toilet trained_______

How active as a baby?

Significant disturbances during childhood (including losses, family illness, separation, tantrums, trauma, etc.)

Personality as child (shy, restless, overactive, withdrawn, outgoing, timid, athletic, playful, etc.):

List any achievements, accomplishments and what factors contributed to such:

The following questions are designed to assist us in working most effectively with your family. Please take a few moments to complete.

List the positive qualities, interest and accomplishments of Participant:

Has Participant experienced any traumatic events or major changes in his/her life?

What are your goals for the Participant's education?

What are your goals for your partnership with OPI?

Favorite academic subject:

Favorite activities:

Describe the Participant's role in the family:

Is there any important cultural or religious information we should know about?

Recreation:
List favorite recreation/leisure activities as a child (reading, playing with friends, sports, coloring/painting, etc.) and those he/she currently has.

Support Systems:
What positive support systems does the Participant have? (Friends, sports, clubs, teachers, clergy, activities, relatives, etc.)

Have these support systems changed in the past year? If yes, please explain:

Employment History:
If the Participant has been employed, for pay or as a volunteer, please indicate where, when, and how they did:

Peer Relationships
Describe the Participant's friends and social relationships:

Sexual Relationship History
Sexual behavior (to what extent is Participant sexually active, has he/she had more than one partner, use birth control?):

Current relationship with significant other (feelings, sexual, communication, conflicts, parenting, etc.):

Substance Abuse
Please list and indicate frequency and intensity of any use of alcoholic beverages or street drugs (marijuana, speed, cocaine).

Starting at what age: Socially or alone?

Under what circumstances or stresses?

How often?

How much?

Are there other family members who have drug or alcohol problems? Please explain:

Has the applicant ever experienced or exhibited any of the following? If yes, please explain:

Has the applicant been held back a grade?

Has the applicant been expelled or withdrawn from school?

Any history of fire setting?

Has there been any suicide discussion or attempt?

Assaultive behavior?

Self abuse?

Physical or sexual abuse?

Has the student ever been arrested?

Convicted? If yes, when?

Why:

Outcome:

Name of Person completing this form (Printed Name): ____________________________________

Signature of person completing this form: ____

EDUCATIONAL INFORMATION

Please list all schools the applicant has attended from 9th grade through 12th grade. Also include colleges or other relevant educational programs.

School Name: ____

Mailing Address: ____

Grade Level: ________________________ Diploma or Degree: ____________________________

Reason for change: ____

School Name: ____

Mailing Address: ____

Grade Level: ________________________ Diploma or Degree: ____________________________

Reason for change: ____

School Name: ____

Mailing Address: ____

Grade Level: ________________________ Diploma or Degree: ____________________________

Reason for change: ____

Special Information

1. Will you need tutoring in any subjects? ____
2. What are your best subjects? ____
3. Do you know what your major will be? ____
4. Do you want specialized training in any area? ____
5. Additional Comments: ____

TREATMENT HISTORY

List below all professional and/or personal efforts that have been made to address your son/daughter's emotional, behavioral, or substance abuse problems (i.e., therapy, hospitalizations, treatment programs, placement, etc.). List the most current treatment first; include addresses and telephone numbers. Add additional sheets if needed.

Intervention 1: ____

____

Reason: ____

____

Professional/Therapist: ______________________________ Credentials: ______________________

Address: ____

Telephone: (_____) ____

Your assessment of treatment outcome: ____

____

____

Intervention 2: ____

____

Reason: ____

____

Professional/Therapist: ______________________________ Credentials: ______________________

Address: ____

Telephone: (_____) ____

Your assessment of treatment outcome: ____

____

____

Intervention 3: ____

____

Reason: ____

____

Professional/Therapist: __________________________ Credentials: ___________________

Address: ____

Telephone: (_____) ____

Your assessment of treatment outcome: ____

____

____

Intervention 4: ____

____

Reason: ____

____

Professional/Therapist: __________________________ Credentials: ___________________

Address: ____

Telephone: (_____) ____

Your assessment of treatment outcome: ____

____

____

Name of Person completing this form (Printed Name): ______________________________

Signature of person completing this form: _______________________________________

MEDICAL HISTORY

Participant's name: ____

Person completing form and relation: ____

1. Does client wear contacts or glasses? _______ If yes, when are they required? Reading only: _______

   In classroom: _______ Driving: _______ All the time: _______ Attach prescription.

2. Date of last dental exam: ______________________ Dentist's name: ___________________________

   Orthodontal work? _________________________ Address: __________________________________

   City, State, Zip: ____________________________ Phone Number: ____________________________

3. Problems with speech or hearing? ____________ If yes, please explain: _________________________

   ____

4. Are there any current health problems? ____________ If yes, please explain: _____________________

   ____

5. Family Physician's Name: ____

   Address: ____

   City, State, Zip: ____

6. List all hospitalizations for medical reasons:

   Date: __________ Hospital Name: ____

   ____

   ____

7. List all hospitalizations for psychiatric reasons.

   Date: __________ Hospital Name: ____

   ____

   ____

8. List all operations:

   Date: __________ Physician Name: ____

   ____

   ____

9. List all accidents involving Participant:

   ____

____

10. Has the Participant ever broken a bone? Please list:

   ____

____

11. List all drug allergies and detailed descriptions of reaction:

   Drug: ____________________________ Reaction: ________________________________

   ____________________________ ________________________________

   ____________________________ ________________________________

12. List all food or environmental allergies. Please explain:

   Allergy:____________________________ Reaction: ________________________________

   ____________________________ ________________________________

   ____________________________ ________________________________

13. List all medications Participant is currently taking, including all prescription and over the counter drugs:

   ____

   ____

14. List all street drugs and alcoholic beverages currently being used in the past and approximate amount ingested weekly by the Participant.

   ____

   ____

   ____

15. Indicate which of the following diseases, illnesses or problems the Participant has had. Please give dates.

Red measles (10 days)	___________	Epilepsy	___________
German measles (3 days)	___________	Scarlet Fever	___________
Venereal Disease	___________	Polio	___________
Scoliosis	___________	Whooping Cough (croup)	___________
Chicken Pox	___________		
Mumps	___________		
Rheumatic Fever	___________		
Convulsions or seizures	___________		
Meningitis, Encephalitis	___________		
Pneumonia, Bronchitis	___________		
Heat Disorder	___________		
Bladder or Kidney Infection	___________		
Frequent ear infections	___________		
High Blood Pressure	___________		
Diabetes	___________		
Dermatitis, Eczema	___________		
Bone condition	___________		
Knee problems	___________		
Arthritis	___________		
Frequent colds/Sore throats	___________		
Ulcers	___________		
Muscle weakness	___________		
Anemia	___________		
Frequent Constipation/			
Diarrhea	___________		

16. Please list other significant illnesses, diseases, or disorders not listed above. Please include dates.

____

____

____

____

17. Please list any relatives of the Participant who have had any of the following illnesses, diseases, or disorders.

Condition	**Yes**	**No**	**Relation to Student**
Tuberculosis	______	______	____________________
Bleeding Disorders	______	______	____________________
Epilepsy or Convulsions			
Cardiovascular Disease	______	______	____________________
Diabetes	______	______	____________________
Kidney Disease	______	______	____________________
Cancer	______	______	____________________
High Blood Pressure	______	______	____________________
Muscle Disorder	______	______	____________________
Others?	______	______	____________________

18. Complete the Immunization History: List month and year each dose was given.

	1st	2nd	3rd	4th	5th
Polio					
DPT or TD					
Measles					
Rubella					
Mumps					
TB Test & Results					

Name of Person completing this form (Printed Name): ______________________________

Signature of person completing this form: ______________________________

MEDICATIONS

____
NAME OF PERSON FILLING THIS OUT & RELATIONSHIP TO PARTICIPANT

______________________ ______________________
PARTICIPANT NAME **DATE**

VERY IMPORTANT! *Please fill out regardless of whether or not your child is on medications. Include any meds he/she stopped taking in the last 60 days. If there are no medications, please so indicate here and initial.*

When listing **ALL** medications your Young Adult currently is taking include the prescription dosages (be sure to state physician's instructions for taking each med). List all vitamins, epinephrine allergy kits and non-prescription drugs, etc.

Medication Information and History

In order to help gain a better understanding of our Participant's history and medication record, we request that you complete the following information. (Please continue on the next page if necessary.)

Medication: ____________________ mg. Dosage: ___________ Instructions:___________________

Reason: ___________________

Start Date: ______________________________ End Date: ________________________

Prescribing Physician:____

Address:____

Telephone: (_____)__________________

Medication: ___________________ mg Dosage: ____________ Instructions: __________________

Reason: ___________________

Start Date: ______________________________ End Date: ________________________

Prescribing Physician:____

Address:____

Telephone: (_____)__________________

____
NAME OF PERSON FILLING THIS OUT & RELATIONSHIP TO PARTICIPANT

_________________________ _________________
PARTICIPANT NAME **DATE**

Medication: ______________________ mg Dosage: _____________ Instructions: ___________________

Reason: _____________________

Start Date: _________________________________ End Date: ___________________________

Prescribing Physician:____

Address:____

Telephone: (_____)____________________

Medication: ______________________ mg Dosage: ____________ Instructions: _____________________

Reason: _____________________

Start Date: _________________________________ End Date: ___________________________

Prescribing Physician:____

Address:____

Telephone: (_____)____________________

Medication: ______________________ mg Dosage: _____________ Instructions: ___________________

Reason: _____________________

Start Date: _________________________________ End Date: ___________________________

Prescribing Physician:____

Address:____

Telephone: (_____)____________________

____
NAME OF PERSON FILLING THIS OUT & RELATIONSHIP TO PARTICIPANT

_____________________ _________________
PARTICIPANT NAME **DATE**

Medication: ____________________ mg Dosage: ____________ Instructions: __________________

Reason: ___________________

Start Date: ______________________________ End Date: _________________________

Prescribing Physician: ____

Address:____

Telephone: (_____)__________________

Please explain Participant's history with regards to taking medications (e.g. resists, hordes, irregular, etc.):
____
____

Has the Participant's recently been taken OFF any medications? If yes, please explain types and circumstances:
____
____

Is the Participant allergic to any medications? Yes _____ No _____
If yes, please list the medications:
____
____

Please indicate allergic reactions: ____
____

Are there any known side effects for this Participant:
____
____

Other medications or related information not listed above:
____
____

PHYSICAL EXAMINATION-*Required for Enrollment*
To be completed 30 days prior or 7 days after start date

NAME____________________________________DATE OF EXAM____________________
BIRTHDATE;_____________PULSE;__________________ WEIGHT;_________________
AGE;_________ SEX: M F BLOOD PRESSURE;____________HEIGHT;_____________

EXAM

Integument__________________________________ Head___________________________
Eyes: Glasses?__________ Vision- R_________ L_________ Fundiscopic______________
Ears:__________________ Chest:_________________Neurological:_____________________
Nose:__________________ Heart:_________________ Musculoskeletal:__________________
Throat:_________________ Abdomen:________________ Scoliosis?____________________
Neck:__________________ Genitalia:________________ Lymph:_______________________
Significant findings or recommendations:____
____
Are there any physical impairments which would limit this person's ability to participate in vigorous physical activities?____
____
Current medical problems under treatment: ____
Current continuous prescribed medications and dosages:________________________________
____
List any contra-indicated medications:____
____

Suggested over-the-counter medications for the following symptoms: **Only listed medications will be allocated:**
Fever/pain________________ hay fever__________________menstrual cramps_____________
Stuffy nose________________ cough___________________ upset stomach_______________
List environmental allergies____

REQUIRED LABORATORY TESTS AND IMMUNIZATIONS: Please attach results:

1. Urinalysis_________________________ 6. Gonorrhea (if indicated)_______________
2. CBC w/differential__________________ 7. Tuberculosis skin test within 1 year:
3. Fasting Glucose____________________ date_______ results______ treatment______
4. VDRL____________________________ 8. Tetanus within 10 years—date:________
5. Pregnancy Test______________________ 9. HIV______________________________
10. Hepatitis B________________________

______________________________ Address:__________________________
Physician's Signature __________________________
Phone Number:_____________________

OPTIMUM PERFORMANCE INSTITUTE, INC.
ENROLLMENT AGREEMENT

This ENROLLMENT AGREEMENT ("Agreement") is made and entered into effective as of the _________________________(mm/dd/yyyy) by and between OPTIMUM PERFORMANCE INSTITUTE, INC., a California Corporation, ("OPI"), on the one hand, and ________________ ("Participant") and ________________ ("Sponsor") on the other hand.

RECITALS

WHEREAS, OPI offers programs, facilities and staff to help young adults ages 17 to 28 years old find the internal balance and external support they need to make a seamless transition into adulthood; and

WHEREAS, Participant is a young adult who is in need of the type of service offered by OPI; and

WHEREAS, Sponsor is the parent/legal guardian of Participant, or is otherwise concerned about the welfare of Participant, and is willing to assume financial responsibility for the cost of the OPI programs and otherwise provide financial, emotional, and other support for Participant while he/she is enrolled in the OPI programs.

NOW THEREFORE, in consideration of the foregoing recitals and the mutual promises and covenants contained therein, the parties hereto hereby agree as follows:

1. OPI's Obligations.

During the term of this Agreement OPI shall offer to Participant some or all of the services and facilities as per the enrollment fee invoice for the indicated period. In addition if Participant wishes to add other services or to add additional sessions to those listed in the invoice, OPI shall provide those additional services provided the fees for such services are paid in advance.

2. Participant's Obligations.

A. During the term of this Agreement, and any extensions thereof, Participant shall be obligated to:

(1) Participate fully in the OPI Out-patient program for the length of the workshops/groups that are agreed upon, including regular attendance at and meaningful, good faith participation in the Out-Patient services provided

(2) Abide by the OPI Precepts and Rules;

(3) Responsibly work toward achieving the goals and objectives set out by the participant and OPI staff

(4) Support the positive growth of others involved in the OPI Out-Patient program;

B. Participant hereby authorizes OPI and any and all of its representatives to release to Sponsor any and all information regarding Participant's participation and progress in OPI. Such information may be conveyed orally in person or by telephone, in writing using internet or email communications, or by any other means. OPI will take reasonable steps to preserve and protect Participant's privacy and confidentiality.

3. Sponsor's Obligations.

A. Pay the fee due to OPI in full and up front for the Out-patient services being rendered. Payment can be in the form of cash, credit card or check

B. Pay for the repair or replacement of any damaged property or equipment caused by the acts or omissions of the Participant.

C. Actively support the goals and objectives of the Participant.

4. Term of Agreement.

A. The initial term of this Agreement is one (1) week.

B. Thereafter, Participant and Sponsor can, subject to OPI approval, elect to extend the Agreement for one or more additional services by giving OPI notice of such election

C. Sponsor agrees to pay a late charge in the maximum amount allowed by law (not to exceed 2% per month) for any additional fees incurred not paid in a timely manner.

J. OPI is a program of limited enrollment and it makes advance arrangements for the accommodation, instruction and treatment of each of its Participants. Therefore, **all fees are non-refundable** and are retained by OPI even if the Participant leaves the OPI Out-Patient program prior to the end of the original or any extended term of this Agreement for any reason including but not limited to temporary or permanent suspension, voluntary temporary or permanent absence or attendance during Participant's enrollment at OPI.

6. Assumption of Risk, Waiver of Liability, and Agreement to Indemnify.

Sponsor and Participant represent and warrant that Participant is physically capable of participating in the Out-Patient Services. Sponsor and Participant represent and warrant that if Participant is aware of, or under treatment for, any physical infirmity, ailment or illness, Participant's medical care provider knows of and has approved Participant's participation in the Activities. Sponsor and Participant acknowledge that they, and they alone, are solely responsible for Participant's personal health and safety.

Sponsor and Participant intend by this Waiver and Release to release, in advance, and to waive their rights and discharge each and every one of the Released Parties, from any and all claims for damages for death, personal injury or property damage which Sponsor and Participant may have, or which may hereafter accrue to Sponsor and Participant as a result of Participant's participation in any aspect of the Programs, even though that liability may arise from negligence or carelessness on the part of the persons or entities

being released, from dangerous or defective property or equipment owned, maintained or controlled by them or because of their possible liability without fault. Additionally, Sponsor and Participant covenant not to sue any of the Released Parties based upon their breach of any duty owed to Sponsor and Participant as a result of Participant's participation in any aspect of the Programs. Sponsor and Participant understand and agree that this Waiver and Release is binding on their heirs, assigns and legal representatives and that the Released Parties shall be exempt from liability to Sponsor and Participant, their heirs, assigns and legal representatives.

Sponsor and Participant agree to hold harmless and indemnify the Released Parties from any and all actions, causes of action, claims, demands, damages, costs (including attorneys fees), expenses, liabilities and charges, known or unknown (the "Liabilities") arising out of or in connection with claims and/or actions relating to or brought by or on behalf of any third party as the result of any act or omission by Participant related to or arising out of the Participant's participation in the services of OPI.

This instrument shall inure to the Released Parties' benefit as well as to the benefit of their successors, assigns, licensees, and other successors-in-interest and is executed with full knowledge that the Released Parties intend to rely and act pursuant to the consent hereinabove granted, and that the Released Parties would not do so in the absence of this instrument.

7. DISPUTE RESOLUTION.

A. MEDIATION.

In the event of any dispute between the Parties to this Agreement in any way related to or arising from this Agreement or the services provided by OPI, prior to the initiation of the arbitration provided for herein, the Parties shall make a good faith attempt to resolve the dispute through mediation with a mutually selected neutral mediator. All costs of mediation, including the costs of the mediator, shall be borne equally by OPI and the Sponsor and California law shall apply to any such mediation.

B. ARBITRATION.

ANY DISPUTE OR CONTROVERSY ARISING OUT OF, UNDER, IN CONNECTION WITH, OR IN RELATION TO, THIS AGREEMENT WHICH CANNOT BE RESOLVED BY THE PARTIES THEMSELVES OR THROUGH MEDIATION SHALL BE SUMBITTED TO BINDING ARBITRATION IN LOS ANGELES COUNTY, CALIFORNIA, WHETHER PRIVATELY ARRANGED BETWEEN THE PARTIES, OR IN ACCORDANCE WITH THE PROVISIONS OF THE CALIFORNIA ARBITRATION ACT, CODE OF CIVIL PROCEDURE SECTION 1280 ET. SEQ. (THE "ACT") EXCEPT TO THE EXTENT THE PARTIES MUTUALLY AGREE OTHERWISE AS PROVIDED IN THIS AGREEMENT.

(1) Arbitrator.

The arbitration shall be conducted by one (1) "neutral arbitrator", as that term is defined in the Act, who shall apply California law. The arbitrator shall be a retired judge of the Superior Court selected by the parties; if the parties are unable to agree on the selection of an arbitrator, then the arbitrator shall be selected in accordance with the terms of the Act, as modified by this Agreement. The arbitration shall be conducted expeditiously. The arbitrator shall issue the arbitration award in writing, setting forth the reasons for the arbitrator's decision. Any award rendered by the arbitrator shall be binding upon each and all of the parties,

and their successors in interest, and judgment thereon may be entered in any court of competent jurisdiction.

(2) Limited Discovery.

Each party is entitled to a limited amount of discovery, including not to exceed two depositions, sufficient to adequately arbitrate their claims. Unless otherwise agreed upon by the parties, discovery shall be limited by the agreement of the parties or the arbitrator so as to maintain the arbitration as a speedy and economical method of dispute resolution.

(3) Remedies.

All remedies and damages that would be available under the applicable law for the parties' claims in a court proceeding are available to the parties through arbitration of their claims, except that the arbitrator shall not have authority to award any punitive or exemplary damages and any such award will be null and void.

(4) Costs/Attorney's Fees.

All attorney's fees and costs are to be paid by the party who incurred them.

(5) Proceedings Confidential.

The arbitration proceedings shall be kept confidential, private, and under seal. To that end, the parties and the arbitrator shall not disclose the existence, content, or results of any proceedings conducted, and materials submitted in connection with such proceedings shall be kept confidential and shall not be admissible in any other proceeding.

8. Entire Agreement; Modification.

This Agreement contains the entire understanding of the Parties with respect to the subject matter of the Agreement, supersedes all prior agreements, oral or written, and all other communications between the Parties relating to such matters. This Agreement may not be amended or modified except by mutual written agreement.

9. Governing Law.

This Agreement is governed by and shall be construed in accordance with the laws of the State of California. The provisions of this Paragraph shall survive expiration or other termination of this Agreement regardless of the cause of termination.

10. Notices.

All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier addressed as follows:

If to OPI: 3080 Eucalyptus Hill Road, Santa Barbara, CA 93108

If to Participant: ____
Participant Home Address

If to Sponsor: ____
Parent/Sponsor Address

or to such other persons or places as either party may from time to time designate by written notice to the other party pursuant to this Section 10.

11. Assignment.

Neither party shall assign or transfer, in whole or in part, this Agreement or any of his/her/its rights, duties or obligations under this Agreement without the prior written consent of the other parties.

Dated: _________________

____
OPI STAFF SIGNATURE

___________________________ ___________________________
PRINT PARTICIPANT NAME PARTICIPANT SIGNATURE

_____________________________ ___________________________
PRINT/SPONSOR PARENT NAME PARENT/SPONSOR SIGNATURE

OPI RULES AND PRECEPTS

At OPI, we believe there are basic rules that are necessary and that must be followed in order for all of us to create a supportive and compassionate environment.

Also, in order for each individual to achieve an internal balance and in order to create a community of individuals who are able to support the emotional growth and well being of others, we feel it is necessary and skillful to define the following rules and precepts that help us accomplish these goals.

OPI RULES

1. I will immediately admit to any violations of any program rules or precepts and will encourage others not to violate the rules and precepts.

2. I will not use or possess drugs, alcohol or other such paraphernalia.

3. I will obey all Federal, State or Community laws as well as all Program rules.

4. I will conduct all sexual activity away from OPI property during the first phase and not engage in sexual activity during OPI-sponsored activities.

5. I will not participate in any acts or threats of violence.

6. I will not possess or use weapons.

7. I will maintain confidentiality in appropriate situations.

8. I will not willfully damage or deface any property belonging to OPI or to others.

Any member of the Community who does not abide by the rules, or is referred to the Executive Committee (which will have Participant representation) will present themselves at the next available meeting. In case of a disagreement between Participants, both parties will appear together. The purpose of an appearance before the Executive Committee is to restore a sense of balance within the Participant and his/her relationship with the Community. The purpose of the Executive Committee is to educate, support and resolve issues related to both the rules and precepts.

I agree to abide by these rules.

Date:__________________________________ __________________________________

Participant Signature

OPI PRECEPTS

1. I intend to train myself to do everything to the best of my ability.
2. I intend to train myself to establish a state of inner balance so I can live my life with integrity.
3. I intend to train myself to help others so my actions will not cause them to violate their precepts.
4. I intend to train myself not to steal, lie or cheat.
5. I intend to train myself not to use alcohol or drugs or delude myself with negative and/or destructive beliefs or ideas.
6. I intend to train myself not to devalue others.
7. I intend to train myself not to be mean in giving help.
8. I intend to train myself to learn to be patient and persevere so I can follow through on my commitments.
9. I intend to train myself to understand that if I fall short of my intentions either accidentally or deliberately, I will blame no one but try again to keep to my original intention as well as accept the consequences of what I have done, for this will teach me how to find balance and happiness within myself and create a safe and supportive community.

I agree to abide by these Precepts.

Date:___________________________ ____

Participant's signature

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO OPI

Date: ______________ Participant: ___________________________ DOB: ___________

I, _________________________________, hereby authorize the following Facility/Physician/Mental Health Professional to release/exchange records including any information related to medical, surgical, psychological, social, psychiatric and/or substance abuse, diagnosis, treatments, prognosis, counseling, court or legal proceedings, and/or therapy there-in contained.

Name of Facility/Physician/Mental Health Professional: -

____

____

____

Please direct the information to: ___________________ ____________________________

NAME E-MAIL ADDRESS

I specifically authorize the following information be released

____ Discharge Summary
____ Psychiatric Evaluation
____ Psychological Testing
____ Immunization Record
____ Physician Progress Notes
____ Operative Report
____ History and Physical Examination
____ Court Records
____ Probation Records
____ Adoption Records
____ Lab, Radiological Reports
____ Physician Orders
____ Medication Records
____ Consultation Records
____ Other: ____

This information is needed for the following purpose(s):

____ Continued Care ____ Other: _________________

This authorization is good for one (1) year from the date signed at which it will be null and void. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon. I understand revocation must be in writing.

Participant ____ DOB: ________________

____
Date

____ _________________

Parent/Sponsor (not necessary if Participant is 18 or over) Date

AUTHORIZATION FOR OPI TO RELEASE/EXCHANGE INFORMATION

I, ______________________________ hereby authorize the Optimum Performance Institute to disclose OPI treatment information and records on ___________________________ to:
(Participant Name)

PARENT(S)/GUARDIAN/FINANCIAL SPONSOR:
Name(s):____________________________
Phone______________________
E-mail: ____________________

OTHER:
Name(s): ____________________
Phone:______________________
E-mail: ____________________

REFERRAL SOURCE:
Name:______________________________
Phone:______________________________
E-mail: ____________________

OTHER:
Name(s):____________________
Phone:_____________________
E-mail: ____________________

OTHER:
Name:______________________________
Phone:______________________________
E-mail: ____________________

OTHER:
Name(s):____________________
Phone:_____________________
E-mail: ____________________

The disclosure of this information is for the following purpose: To provide the greatest quality of care by working collaboratively with those who could be of assistance to the participant. This may include weekly updates as to the status and progress of the participant. Information to be released may include (please check):

Treatment plan and goals ☐ Diagnosis ☐ Discharge Planning ☐
Progress updates ☐ Medication changes ☐ Drug/Alcohol test results ☐
Behavioral interventions ☐
Other ☐________________________________

The transmission of this information my be telephone, mail and or email. OPI will take all precaution regarding electronic transmissions, however, E-mail transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. Therefore OPI does not accept liability for email transmissions once it leaves our systems. Limitations of information to be discussed are as follows: Information will not be released by OPI if it is believed that to release it would be harmful or detrimental to the participant's treatment.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing and I have a right to revoke it at any time.

This authorization shall remain valid for the entire time of receiving treatment at OPI and up to 30 days after discharge.

Participant Name:_________________________

Participant Signature: ______________________ Date:__________

Parent/Sponsor/Guardian Signature (if under 18):_________________ Date:__________

ACTIVITIES RELEASE

I am aware that OPI, Inc., in addition to the academic curriculum, general athletic and other training, sponsors recreational activities including, but not limited to hiking, bicycling, and swimming. I am further aware that there are substantial risks inherent in these and the other recreational activities. I hereby release OPI, Inc., its officers, employees, representatives, and agents from any and all liability for property damage and personal injury in any form whatsoever caused by or arising from participation in any and all recreational activities and operations.

I have read this Release and understand all of its terms. I sign this Release voluntarily and with full understanding and knowledge of the claims I am releasing and waiving.

Date: ____________________ Participant Signature: ________________________________

Print Name: ____

I hereby consent to my child's participation in all activities and programs conducted by OPI, Inc. and agree to be bound by the terms of this Release.

Date: _____________________ Parent/Guardian/Sponsor:_____________________________

Print Name: ____

RELEASE OF LIABILITY, WAIVER OF CLAIMS,
ASSUMPTION OF RISK & INDEMNITY AGREEMENT

BY SIGNING THIS DOCUMENT YOU WILL WAIVE CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE

In consideration of participating in the Activities the undersigned hereby agrees to the terms of this "Agreement" as follows:

A. <u>ASSUMPTION OF RISK</u>:

1) I the undersigned wish to participate in the voluntary on and off-site activities organized by Optimum Performance Institute, Inc. dba ROANNE MANOR (hereinafter called "OPI"), which is planned to include, but may not be limited to the following activities ("Activities"):

1. Transportation between OPI facilities or to and from any OPI sponsored on or off-site event;
2. Any and all social events or outings sponsored by OPI or others;
3. Equestrian riding, hiking, walking or any other recreational activities of any kind;

2) I recognize that engaging in the Activities involves certain risk. Those risks include but are not limited to, the risk of injury resulting from automobile accidents that occur during the transportation to and from the Activities, possible malfunction of the animals or equipment used in the Activities and injuries from running, riding, tripping or falling. In addition, I recognize that the exertion of engaging in the Activities or a malfunction associated with Activities could result in injury or death.

3) Despite these and other risks, & fully understanding such risks, I wish to engage in the Activities and hereby assume the risks of doing so. I also hereby hold harmless OPI and hereby indemnify them against any and all claims, actions, suits, procedures, costs, expenses (including attorneys fee's and expenses), damages and liabilities arising out of, connected with or resulting from my engaging in the Activities, including without limitation, those resulting from the manufacture, selection, delivery, possession, use or operation of equipment. I hereby release the Company from any and all such liability and I understand that this release shall be binding upon my estate, my heirs, my representatives and assigns. I hereby certify to OPI that I am in good health and do not suffer from a heart condition or other ailment which could be exacerbated by the exertion involved in engaging in any OPI Activity.

B. <u>RELEASE OF LIABILITY, WAIVER OF CLAIMS, & INDEMNITY AGREEMENT</u>

1) TO WAVE ANY AND ALL CLAIMS that I have or may have in the future against OPI, their directors, officers, employees, agents and representatives.

2) TO RELEASE OPI from any and all liability for any loss, damage, injury, or expense that I may suffer or that my next of kin may suffer as a result of my participation in the Activities due to any cause whatsoever, INCLUDING NEGLIGENCE ON THE PART OF OPI;

3) TO HOLD HARMLESS AND INDEMNIFY OPI from any and all liability for any damage to property of or personal injury to, any third party, resulting from any participation in the Activities.

4) IT IS UNDERSTOOD AND AGREED that this Agreement extends to all claims of every kind and nature whatsoever, known or unknown, suspected or unsuspected and each party to this Agreement expressly waives the provisions of Section 1542 of the California Civil Code with respect to the above-referenced claims which provides as follows:

> *"A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him/her must have materially affected his/her settlement with the debtor."*

5) That this Agreement shall be effective and binding upon my heirs, next of kin, executors administrators and assigns, in the event of my death. In the event of a dispute regarding the provisions of this Agreement, the prevailing party in a litigation filed as a result of said dispute shall be entitled to their costs and reasonable attorneys' fees.

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND I SIGN THIS AGREEMENT VOLUTNARILY AND WITH FULL UNDERSTANDING AND KNOWLEDGE OF THE CLAIMS I AM RELEASING AND WAIVING.

"PARTICIPANT"

Date: ___________________

Signature: ___________________________

____
[Print Name]

IF PARTICIPANT IS UNDER 18 YEARS OF AGE
I hereby consent to the Participant's participation in all Activities and programs conducted by OPI including the transportation to and from the Activities and agree to be bound by each and every term of this Agreement.

Date: ___________________

Signature: _________________________

____
[Print Name or Parent/Sponsor/Guardian]

WAIVER OF NEGLIGENCE, ASSUMPTION OF RISK AND COMPLETE RELEASE OF LIABILITY WHILE TRAVELING OFF PREMISES

By signing this release I promise to free OPI, Inc. and its agents and employees, from any and all responsibility in the event I suffer personal injury or property damage while traveling to or from and off of OPI's premises, whether I am driving in my vehicle or the vehicle of another, or whether I am a passenger in my vehicle, or the vehicle of another, provided the accident is not directly caused by the acts of OPI, INC or its agents and employees, in their operation of a vehicle.

I hereby waive any and all claims of negligence against OPI, Inc. and its agents and employees, that might be asserted because of my negligent operation on any vehicle, or the negligent operation of a vehicle in which I am a passenger, while departing from or returning to OPI, Inc.'s premises, and throughout said travels. This waiver includes claims based upon the absence or inadequacy of operator competence, experience, training, licensing, mental status and ability, and including the lack of adequate maintenance, suitability, safety features and insurance pertaining to the vehicles and/or the operators.

I hereby assume the risk of any serious personal injury and property damage, including death, from my operation of a vehicle, or while a passenger of someone other than an agent or employee of OPI, Inc., and release and hold OPI, Inc. free and harmless from all claims arising therefrom.

It is my intent to exempt and to relieve OPI, Inc. and its agents and employees from all responsibility concerning my choice to travel away from its premises for all social or other purposes.

Furthermore, I hereby agree to maintain automobile liability insurance at all times while I am operation any such vehicle, and I promise to defend and to indemnify and to save OPI, Inc. and its agents and employees free and harmless from any and all claims of liability occasioned by my operation or occupancy of any such vehicle.

In the event of a dispute between OPI Inc. and me, concerning this release, or any breach thereof, the prevailing party shall be entitled to an award of reasonable attorneys' fees and costs.

BY SIGNING BELOW, I ASSERT THAT I HAVE READ AND I AGREE TO ABIDE BY THE TERMS SET FORTH IN THIS WAIVER OF NEGLIGENCE, ASSUMPTION OF RISK AND COMPLETE RELEASE OF LIABILITY WHILE TRAVELING OFF PREMISES

Date: ________________ Participant's Signature: ______________________
Participant's Printed Name: ___________________

Witnessed By: ________________ Date: ________ Signature: _________________
Printed Name:_______________

IF PARTICIPANT IS UNDER 18:

Date: ________________ Parent/Sponsor Signature ________________

Parent/Sponsor Printed Name:_____________

Witnessed By: _____________ Date: _________ Signature : _____________________

Printed Name_____________________

Notice of Privacy Practices

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our program; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, we are legally required to follow the privacy practices described in this Notice.

However, we reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before we make any important changes to my policies, we will promptly change this Notice and post a new copy of it in our office and on our website (*if applicable*). You can also request a copy of this Notice from us, or you can view a copy of it in our office or at my website, which is located at (*insert website address, if applicable*).

III. HOW WE MAY USE AND DISCLOSE YOUR PHI.
We will use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior written authorization; for others, however, we do not. Listed below are the different categories of our uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. We can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. We can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, we can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. We can use and disclose your PHI to bill and collect payment for the treatment and services provided by us to you. For example, we might send your PHI to your insurance company or health plan to get paid for the health care services that we have provided to you. We may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. We can use and disclose your PHI to operate my practice. For example, We might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. We may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. We may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as we try to get your consent after treatment is rendered, or if we try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and we think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. We can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, we may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, we may have to use or disclose your PHI in response to a court or administrative order. we may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, we may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, we may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, we may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, we may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, we may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, we may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that we offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, we will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by us.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Restrictions on My Uses and Disclosures**. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that we restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to us in writing. We will consider your requests, but we am not legally required to accept them. If we do accept your requests, we will put them in writing and we will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that we are legally required to make.

B. The Right to Choose How We Send PHI to You. You have the right to request that we send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that we have on you, but you must make the request to inspect and receive a copy of such information in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to your request within 30 days of receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, we will charge you not more than $.25 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which we have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

We will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of my records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section Vl below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. we will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact us at: (818) 610-3956

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that we have given to you. 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 obtain a copy of the revised notice from us by contacting OPIO at (818) 610-3956, Ext. 209.

If you have any questions about our Notice of Privacy Practices, please contact us.

I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF THE OPTIMUM PERFORMANCE INSTITUTE:

____________________________________ __________________________

Participant/Parent/Guardian/Sponsor Date

____________________________________ __________________________

OPI Representative Date

LETTER OF AGREEMENT REGARDING THE PROVISION OF INDIVIDUAL PSYCHIATRIC CONSULTIVE SERVICES

This letter confirms that I have been asked to provide psychiatric consultative/individual psychotherapy services for ________________________________ who is a Participant at Optimum Performance Institute (“OPI”) in Woodland Hills. Calif. and sets forth the financial terms of the arrangement.

As you know, two psychiatric/ consultative sessions per month are available and are included in the cost of the OPI program. I work collaboratively with the OPI staff to help maximize each Participant’s experience. If I recommend additional sessions per month I will contact you prior to seeing the participant and obtain your permission.

Please call me at my office number which is 818-610-3956 if you have any questions or input that you would like to share with me regarding your young adult’s progress and clinical status.

Psychiatry/ consultative session in addition to the two monthly sessions, therapy sessions are billed as follows:

$250.00 for sessions lasting 30 minutes

$300.00 for sessions from 50 minutes

[I reserve the right to change my fees by giving you thirty (30) days advanced notice.]

I do not bill insurance companies (or third parties) for psychiatric consultative/individual psychotherapy services. If you wish, I can add the CPT and ICD-9 codes so that you may bill your insurance for your own reimbursement. Please indicate that you want this by checking the box below.

☐

If for any reason the Participant chooses to cancel any additional psychiatric consultative session, the Participant is required to give a notice of cancellation 24 hours prior to the appointment or you will be charged for the session.

It is expected that you will remit payment for all serviced rendered within 14 days of the billing date. Late fees of 2 percent may be assessed on late payments. Bills will be mailed to you once a month to the address on this letter. If you have shared financial arrangement, it will be your responsibility to make the arrangements necessary to be reimbursed for payment as it is not appropriate for me to split-bill two parties.

This letter of agreement is a legally binding contract that provides you with important information regarding the billing practices of _________________. By signing below you acknowledge that you are financially responsible for the psychiatrist consultative services provided to the Participant by _________________ that are individualized and approved by financial sponsor, even if the Participant is an adult, and that you have discussed such terms and conditions with _________________, had any questions answered to your satisfaction and agree to abide by the terms and conditions of this letter of agreement.

This letter of agreement also applies to all services rendered by ________________ if the participant chooses to continue care within OPI's After Care Program or in agreements whether oral, written or otherwise heretofore entered into by the parties.

DISPUTE RESOLUTION.

A. MEDIATION.

In the event of any dispute between the Parties to this Agreement in any way related to or arising from this Agreement or the services provided by Dr. Fischer or any other psychiatrist, to participant, prior to the initiation of the arbitration provided for herein, the Parties shall make a good faith attempt to resolve the dispute through mediation with a mutually selected neutral mediator. All costs of mediation, including the costs of the mediator, shall be borne equally by the psychiatrist and the Sponsor and California law shall apply to any such mediation.

B. ARBITRATION.

ANY DISPUTE OR CONTROVERSY ARISING OUT OF, UNDER, IN CONNECTION WITH, OR IN RELATION TO, THIS AGREEMENT WHICH CANNOT BE RESOLVED BY THE PARTIES THEMSELVES OR THROUGH MEDIATION SHALL BE SUBMITTED TO BINDING ARBITRATION IN LOS ANGELES COUNTY, CALIFORNIA, WHETHER PRIVATELY ARRANGED BETWEEN THE PARTIES, OR IN ACCORDANCE WITH THE PROVISIONS OF THE CALIFORNIA ARBITRATION ACT, CODE OF CIVIL PROCEDURE SECTION 1280 ET. SEQ. (THE "ACT") EXCEPT TO THE EXTENT THE PARTIES MUTUALLY AGREE OTHERWISE AS PROVIDED IN THIS AGREEMENT.

PARTICIPANT AND PARENT/SPONSOR SHALL SIGN THE SEPARATE PHYSICIAN-PATIENT ARBITRATION AGREEMENT AT OPI OFFICES.

C. Costs/Attorney's Fees.

If any party to this Agreement initiates an arbitration or any other action or proceeding to interpret or enforce this Agreement, or to obtain damages by reason of any alleged breach of this Agreement, each party to the dispute shall bear their own attorney's fees and costs.

D. Except to the extent necessary to obtain a judgment based upon an arbitration award, each party to this Agreement shall refrain from unnecessarily communicating or publishing any information of a confidential or disparaging nature and all facts communicated in any attempt to resolve disputes shall remain strictly confidential as between the parties.

This is the entire agreement between the parties and no oral representations or comments, and no other writings, except the Physician Patient Arbitration Agreement by be referred to as a part of this agreement.

DATED:_____________________

____
Treating Psychiatrist

____
Participant's Signature

____
Parent/Sponsor's Signature

LETTER OF AGREEMENT REGARDING THE PROVISION OF INDIVIDUAL PSYCHOTHERAPY SERVICES

This letter confirms that I have been asked by you to provide individual psychotherapy services for __________________________________ who is a participant at the Optimum Performance Institute ("OPI") in Woodland Hills, Calif. and sets forth the financial terms of the arrangement.

As you know, two individual psychotherapy sessions per week are provided and are included in the cost of the OPI program. If I recommend additional sessions (more than two times weekly) in the frequency of on-going psychotherapy I will contact you and obtain your approval.

I look forward to working closely with you and will report regularly to you on the progress of your young adult. Part of the therapeutic process is contact and communications with relevant family members who can provide further assistance and insight regarding the participant. Sometimes it is also helpful to communicate with other therapist or consultants who can provide assistance and insight into achieving the designated therapeutic goals of the participant . These communications may be conducted face to face or telephonically. These services are considered an important part of the therapeutic process and are included in OPI fees.

Please call me at the office number, which is 818-610-3956 if you have any questions or input that you would like to share with me regarding you young adult's progress and clinical status.

My fee for individual psychotherapy sessions (in addition to two sessions per week), if indicated. Thereafter, therapy sessions are billed as follows:

$150.00 for session lasting 30 minutes
$185.00 for session from 50 minutes

I do not bill insurance companies (or third parties) for individual psychotherapy services. If you wish, I can add the DSM and/or ICD-9 codes so that you may bill your insurance for your own reimbursement. Please indicate that you want this by checking the box below.

☐

If the Participant chooses to cancel any additional psychotherapy sessions, Participant is required to give notice or cancellation 24 hours prior to the appointment or you will be charged for the session.

It is expected that you will remit payment for all services rendered within 14 days of the billing date. Late fees of 2 percent may be assessed on late payments. Bills will be mailed to you once a month to the address on this letter. If you have a shared financial arrangement , it will be your responsibility to make the arrangements necessary to be reimbursed for payment as it is not appropriate for me to split-bill two parties.

This letter is a legally binding contract that provides you with important information regarding the billing practices of _________________. By signing below you acknowledge that you are financially responsible for the additional individualized psychotherapy services that are and provided to the Participant by
, had any questions answered to your satisfaction and agree to abide by the terms and conditions of this letter of agreement.

This letter of agreement also applies to all services rendered by _______________ if the Participant chooses to continue care within OPI's After Care. This letter of agreement supersedes all prior agreements whether oral, written, or otherwise heretofore entered into by the parties.

DISPUTE RESOLUTION.

A. MEDIATION.

In the event of any dispute between the Parties to this Agreement in any way related to or arising from this Agreement or the services provided by OPI, prior to the initiation of the arbitration provided for herein, the Parties shall make a good faith attempt to resolve the dispute through mediation with a mutually selected neutral mediator. All costs of mediation, including the costs of the mediator, shall be borne equally by OPI and the Sponsor and California law shall apply to any such mediation.

B. **ARBITRATION.**

ANY DISPUTE OR CONTROVERSY ARISING OUT OF, UNDER, IN CONNECTION WITH, OR IN RELATION TO, THIS AGREEMENT WHICH CANNOT BE RESOLVED BY THE PARTIES THEMSELVES OR THROUGH MEDIATION SHALL BE SUBMITTED TO BINDING ARBITRATION IN LOS ANGELES COUNTY, CALIFORNIA, WHETHER PRIVATELY ARRANGED BETWEEN THE PARTIES, OR IN ACCORDANCE WITH THE PROVISIONS OF THE CALIFORNIA ARBITRATION ACT, CODE OF CIVIL PROCEDURE SECTION 1280 ET. SEQ. (THE "ACT") EXCEPT TO THE EXTENT THE PARTIES MUTUALLY AGREE OTHERWISE AS PROVIDED IN THIS AGREEMENT.

PARTICIPANT AND PARENT/SPONSOR SHALL SIGN THE SEPARATE PHYSICIAN-PATIENT ARBITRATION AGREEMENT AT OPI OFFICES.

(1) Arbitrator.

The arbitration shall be conducted by one (1) "neutral arbitrator", as that term is defined in the Act, who shall apply California law. The arbitrator shall be a retired judge of the Superior Court selected by the parties; if the parties are unable to agree on the selection of an arbitrator, then the arbitrator shall be selected in accordance with the terms of the Act, as modified by this Agreement. The arbitration shall be conducted expeditiously. The arbitrator shall issue the arbitration award in writing, setting forth the reasons for the arbitrator's decision. Any award rendered by the arbitrator shall be binding upon each and

all of the parties, and their successors in interest, and judgment thereon may not be entered in any court of competent jurisdiction.

(2) Limited Discovery.

Each party is entitled to a limited amount of discovery, including not to exceed two depositions, sufficient to adequately arbitrate their claims. Unless otherwise agreed upon by the parties, discovery shall be limited by the agreement of the parties or the arbitrator so as to maintain the arbitration as a speedy and economical method of dispute resolution.

(3) Remedies.

All remedies and damages that would be available under the applicable law for the parties' claims in a court proceeding are available to the parties through arbitration of their claims, except that the arbitrator shall not have authority to award any punitive or exemplary damages and any such award will be null and void.

(4) Costs/Attorney's Fees.

All attorney's fees and costs are to be paid by the party who incurred them.

(5) Proceedings Confidential.

The arbitration proceedings shall be kept confidential, private, and under seal. To that end, the parties and the arbitrator shall not disclose the existence, content, or results of any proceedings conducted, and materials submitted in connection with such proceedings shall be kept confidential and shall not be admissible in any other proceeding, except in a proceeding to enforce the award by obtaining judgment.

Entire Agreement; Modification.

This Agreement contains the entire understanding of the Parties with respect to the subject matter of the Agreement, supersedes all prior agreements, oral or written, and all other communications between the Parties relating to such matters. This Agreement may not be amended or modified except by mutual written agreement.

Governing Law.

This Agreement is governed by and shall be construed in accordance with the laws of the State of California. The provisions of this Paragraph shall survive expiration or other termination of this Agreement regardless of the cause of termination.

Notices.

All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier addressed as follows:

If to OPI: 3080 Eucalyptus Hill Road, Santa Barbara, CA 93108

If to Participant:

____

Participant Home Address

If to Sponsor:

____

Parent/Sponsor Address

or to such other persons or places as either party may from time to time designate by written notice to the other party pursuant to this Section 10.

Dated: ______________________________

____
Therapist signature

_____________________________________ _____________________________________
Participant's Signature Parent/Sponsor's Signature

_____________________________________ _____________________________________
Print Name Print Name

CANCELLATION POLICY/NO SHOW POLICY

This policy applies to all one-on-one and group sessions scheduled by

OPTIMUM PERFORMANCE INSTITUTE, INC.
Roanne Program
Intensified Outpatient Program
Individual MD's and Therapists
Group Therapy, workshops, education services and career and volunteer services activities

In all cases where an appointment has been made for and accepted by a residential participant, an AfterCare participant or an outpatient for any of the foregoing activities and the appointment is not canceled in a timely manner (**at least 24 hours prior to the scheduled appointment**) and the activity was undertaken without the individual being in attendance, or would have been undertaken had the individual kept the appointment, the activity will be considered as having been attended by the individual and will be billed or accounted for accordingly.

This means that, for a residential participant, an AfterCare participant or an Intensified Outpatient Program participant who has a specified number of group and/or individual sessions included in his/her enrollment agreement, the missed appointment will be counted as having been completed. This also means that, for any other outpatient activity not included in an enrollment agreement, the individual will be billed for the session as if it had been attended.

In the event of the late arrival of an individual to any session for which an appointment has been made, the individual may be permitted to join the session in progress at the sole discretion of the individual (MD, therapist or group leader) who is in charge of the session.

Exceptions to this policy can be made by OPI's Program Director in consultation with the individual who is in charge of the session.

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I understand and agree to the forgoing and will accept all charges associated with the implementation of this policy.

Participant Signature ____________________________________ Date __________________

Printed Name ____

STATEMENT OF AUTHENTICITY---PART I

Name of person(s) completing application:

____

____

Address: _________________________________ City, State, Zip: ________________________

Phone Numbers: Home: (_____) ______________________ Work: (_____) ___________________

If not applicant, relationship to applicant:

____

Address: _________________________________ City, State, Zip: ________________________

Phone Numbers: Home: (_____) ______________________ Work: (_____) ___________________

If not applicant, relationship to applicant:

____

I certify that all information in this application is true and complete to the best of my knowledge:

______________________________	______________________________
Date	Date
______________________________	______________________________
Signature of Preparer	Signature of Preparer

____

Date

____

Signature of New OPI Participant