ALL AROUND ACHIEVERS, LLC
PLACEMENT AGREEMENT FORM 720

I CERTIFY THAT I HAVE READ, SIGNED AND/OR RECEIVED THE FOLLOWING DOCUMENTS/ INFORMATION:
1. Consent to Treatment/Emergency/Medical/Dental
2. Rights and Responsibilities
3. Notice of Privacy Practices
4. Resident and Parent/Guardian Handbook (therapeutic pass leaves) - I have been educated about and agree to the use of behavior management and treatment interventions, including level systems as defined in the Resident and Parent/Guardian Handbook. Target behaviors for which these procedures may be used have been explained to me.
5. Financial Agreement
6. Authorization for Medications Currently Being Prescribed:

Current medications prescribed by an attending physician are:

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<th>Medication</th>
<th>Dosage</th>
<th>Route</th>
<th>Times</th>
<th>Prescribing Doctor</th>
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The undersigned consents to the attending psychiatrist/clinician to prescribe the medications listed and perform a PPD test, Hepatitis vaccine, Meningitis vaccine and Tetanus toxoid vaccine if indicated. The undersigned understands that THE FACILITY, physician, or staff will discuss any new and/or changed medications with the undersigned.

RESIDENT NAME   RESIDENT SIGNATURE   DATE/TIME

LEGAL GUARDIAN NAME   LEGAL GUARDIAN SIGNATURE   DATE/TIME

Authorize & Consent for Treatment for resident placement
The undersigned authorizes the All Around Achievers, LLC (THE FACILITY), it’s staff, and attending physicians to render to the resident all customary care, therapy, treatment, tests, and procedures considered advisable, including emergency treatment and transportation to another facility if necessary. Further consent is also given for any educational testing, diagnostic procedures, medical treatment, recreational activities and therapy, and other treatment ordered by the attending physician including, but not limited to, services provided by other Healthcare Professionals to the resident.

All Around Achievers, LLC have the right and consent to schedule any type of appointments (School, Medical, Dental, Legal, etc.) ALC also has the right to make any final decisions on Medication, Surgeries, Counseling, Educational, etc.

The undersigned affirms that he has retained no other medications on his person and agrees that all medications must he dispensed by the pharmacy or by a trained and authorized employees while he is on the premises of THE FACILITY.

The undersigned acknowledges certain healthcare professionals furnishing services to the resident, including, but not limited to, psychiatrists, psychologists, physical therapists, social workers, and/or counselors may be independent

Client:    Date:_________________
contractors and may not be employees or agents of THE FACILITY. The undersigned further recognizes that the resident may be billed separately by their attending physicians and/or other healthcare professionals for their services provided.

**Consent for Admission to All Around Achievers, LLC**

The undersigned acknowledges that no guarantee or assurance has been made to them, or the resident, as to the results of any services provided to the resident, including, but not limited to, therapy, treatment, tests, or procedures, while a resident of THE FACILITY. The undersigned further understands that, unless otherwise disclosed, THE FACILITY does not employ physicians and that the resident's admitting physicians, or a physician to whom the resident may be referred and any other physician who may consult or provide services to the resident are not employed by and are not agents of THE FACILITY, but are independent physicians who exercise their judgment in the services they render to residents.

The undersigned consents to the taking photographs for the purpose of identification. These photographs may be permanently retained in the resident’s medical record.

**Consents for Release of Information**

The undersigned authorizes THE FACILITY to release all resident information, including specific information regarding diagnosis, treatment and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the resident is being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS) while at THE FACILITY. This information may be release to any insurance company, and/or third party payers, or representative providing coverage for this admission, or to any FACILITY representative including, but not limited to, employees, attending physicians, or other healthcare professionals and organizations. This information may not be released to any other person or entity unless the undersigned so authorizes.

The undersigned acknowledges that such disclosures shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the person(s) or entities to which the information is released.

The undersigned further authorizes THE FACILITY to release information for the purpose of obtaining pre-authorization for residential treatment and concurrent review and to release that information to medical review agencies and/or third party payers providing coverage or having responsibility for this admission.

The confidentiality of resident records which reflect alcohol and drug abuse is protected by Federal law and regulations. Generally, THE FACILITY may not disclose information to anyone outside THE FACILITY which would IDENTIFY any resident as an alcohol or drug abuser unless the resident has consented in writing; the disclosure is allowed by court order, or the disclosure is made to medical or other qualified personnel in accordance with Federal regulations.

Federal law and regulations do not protect information regarding a crime or a threat to commit a crime or any information regarding suspected child abuse or neglect from being reported to appropriate State or local authorities.

The undersigned also hereby authorizes free exchange of medical record information, including, but not limited to, the release of resident information indicated above between THE FACILITY and the attending physician, his group practice association, and/or other healthcare agencies, facilities, and/or professionals which may provide services to resident during his admission.

The undersigned may request to receive a copy of this Authorization for release of information and may revoke this Authorization at any time, except to the extent that action has been taken in reliance thereon. The undersigned acknowledges that this authorization shall be valid until all third party payers liability is resolved for this admission.

**Consent for Follow-up Contact**

The undersigned consent(s) to THE FACILITY, staff members or other healthcare professionals contacting the resident or family member by telephone in approximately six months to one year. THE FACILITY makes periodic contact with those who have used its services, using the information to improve its services to residents and to make sure THE FACILITY is addressing residents' needs. Specific responses are not disclosed; only summary information is assembled. This contact may also include, but not be limited to, information sent from THE FACILITY on current educational programs and newsletters.

**Acknowledge Receipt of Resident Rights**

The undersigned acknowledges that a copy of the Resident Rights has been given to them; that these rights have been explained; and that they understand these rights.

**Responsibility for Destruction of Property or Lost Property**

The undersigned acknowledge(s) that residents are responsible for any damage to or destruction of THE FACILITY property, or property belonging to others which may be located at THE FACILITY. The undersigned agree to accept
liability for, and reimburse THE FACILITY or other owners of property which the resident may damage or destroy. The undersigned acknowledges that they have received a copy of the prohibited items of THE FACILITY and that they are not bringing any of those items onto FACILITY property. The undersigned acknowledges that THE FACILITY is not responsible for personal items that are damaged or lost while a resident of THE FACILITY.

Consent for HIV Testing
The undersigned acknowledges that whenever a staff member, resident, or any person employed by or under the direction of THE FACILITY is directly exposed to body fluids of a resident in a manner which may transmit HIV, the resident whose body fluids was involved in the exposure shall be deemed to have consented to testing for HIV infection. The resident is also deemed to have consented to the release of this information to the staff member who was exposed.

Consent for Photographs
The undersigned gives permission for the resident to be photographed while placed at the facility. I understand that photographs will be used for the following reason: Activity Therapy may take picture during activities activities/programs/outings. These pictures may be displayed within the facility only. Photos are destroyed upon discharge. The photos are not used in the media or for marketing purposes. ☐ AGREE ☐ DISAGREE

Assignment of Insurance Benefits
In consideration of residential and medical services rendered or to be rendered by THE FACILITY, to the extent permitted by law, I hereby irrevocably assign, transfer, and set over to THE FACILITY, all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility, and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by THE FACILITY during the pendency of the claim for this admission. Such irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of THE FACILITY to pursue any such right of recovery. THE FACILITY will pursue appeal of denied claims through two levels of appeal. I hereby authorize the insurance company (ies) or third party payor(s) to pay directly to the FACILITY all benefits due for services rendered.

Rights & Responsibilities
Our focus is based on a values based model. Residents receive intervention on a daily basis (as uniquely required per child). Residents receive family therapy when appropriate, individual and group therapy, consultative medical and psychiatric services, medication management and recreational activities. Because we recognize the need for a strong educational component, our group home residents will attend the local middle or high schools. Additionally our residents will mentored academically by a professional tutoring service to further enhance their growth and developmental success.

Visitation
All parent/legal guardians have to right to come and visit resident upon a 24 hour call or notice. This is to ensure that the resident will be available during the visit. If a resident or parent/legal guardian would like to take the resident on a pass it must be requested and approved by the Program Manager.

Education Plan & Responsibility
AAA, LLC is a program that promotes academic achievement. Each resident is required to be enrolled at participating school district in which the address is located. The resident is responsible for attending school daily as well as completing all work assignments. The parent/legal guardian is required to attend all ISP’s, parent/teacher conferences or meetings.

FACILITY Discharge Policy Information
The undersigned understands that it is the policy of THE FACILITY to attempt to provide a structured therapy regimen with effective quality treatment. If the treatment regimen is not completed prior to the exhaustion of the resident’s health insurance benefits, the undersigned agrees to be liable for any charges incurred which are not paid by the insurance in addition to the deductible and/or co-payment liability. It is NOT the policy of THE FACILITY to discharge, transfer, or end the treatment regimen of a resident when insurance has been exhausted.

Guarantee of Payment
The undersigned hereby guarantee payment of the bill for services, including room and board, medical, counseling, daily supervision, physician, behavioral therapeutic services, and education services rendered by THE FACILITY from Admission to discharge. The undersigned agrees whether signing as guarantor, legal guardian, or as patient, that in consideration of the services to be rendered to the resident, to be hereby jointly and individually obligated to pay the account of THE FACILITY in accordance with the regular rates and terms of THE FACILITY. Should the account be
referred for collection by an attorney or collection agency, the undersigned agree(s) to pay all attorney’s fees and other reasonable collection costs and charges that are necessary for the collection of any amounts(s) not paid when due.

**Consent for Therapeutic trial visits/field trips/facility activities**
The undersigned hereby acknowledges that the resident’s attending physician may include in the treatment of a resident, activities or field trips away from THE FACILITY and that the attending physician may at times allow the resident therapeutic trial visits away from THE FACILITY. In consideration of the value to the resident of such treatment, the undersigned hereby: (1) consent to the resident’s participation in fields trips, activities, and therapeutic trial visits; (2) release THE FACILITY, its employees and it’s agents from liability for injury to the resident caused by any act or omission on their part in the course of such field trips, activities, and leaves; and (3) agree to indemnify and hold harmless THE FACILITY, it’s medical staff, it’s employees, and it’s agents from all claims, costs, and losses incurred as a result of any act of the resident while on such field trips, activities and leaves.

**Advance Directive Acknowledgement**
The undersigned acknowledges: (1) have been given materials about my right to accept or refuse medical treatment; (2) I have been informed of my rights to formulate Advance Directives; (3) I understand that I am not required to have an Advance Directive in order to receive medical treatment at this FACILITY; and (4) I understand that the terms of any Advance Directive that I have executed will be followed by THE FACILITY and my caregivers to the extent permitted by law.

☐ I HAVE  ☐ I HAVE NOT executed an Advance Directive

**Financial responsibility for placement**
AAA, LLC is here to provide the best service to each and every client. AAA, LLC will accept Medicaid eligible clients to pay for services. All room and board fees will be based upon certain criteria’s.

**Primary Funding Source:** __________________________________________ ☐ COPY PROVIDED

**Secondary Funding Source:** ________________________________________ ☐ COPY PROVIDED

**Educational Funding:** ______________________________________________

**Daily Fees For Service:**

**CSA and NON-CSA**

ROOM & BOARD………………………………………………………………………………………………$ ________ PER DAY

*FEE FOR THERAPEUTIC BEHAVIORAL SERVICES IS BILLED TO MEDICAID*

Applicability to other providers
The undersigned agrees(s) that in the event other healthcare professional providers, including but not limited to other facilities, furnish services to the resident while in THE FACILITY, the consent(s), assignment(s), guarantee(s), and release(s) herein set above set out shall apply to such other providers and services

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<tr>
<th>RESIDENT’S NAME</th>
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<th>TIME</th>
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<tbody>
<tr>
<td>LEGAL GUARDIAN NAME</td>
<td>LEGAL GUARDIAN SIGNATURE</td>
<td>DATE</td>
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<tr>
<td>FACILITY STAFF NAME</td>
<td>FACILITY STAFF SIGNATURE</td>
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Client: _________________________  Date: _________________________