Pathways
the power to change

INTAKE AND ADMISSIONS

Name: _____ Preferred Name: _____ Date: ____/____/____

Date of Birth ____/____/____ Age: _____ Gender: ☐ Male ☐ Female Race/Ethnicity: _____

Preferred Method of Contact: ☐ Cell Phone ☐ Text ☐ Home Phone ☐ Work Phone ☐ Email

Cell Phone: _____Home Phone: _____Can we leave a message? ☐ Yes ☐ No

Work Phone: _____ Email: _____

Social Security #: _____-_____-_____ Driver's License #: _____

Home Address: City: _____ State: _____ Zip: _____

Billing Address (if different): City: _____ State: _____ Zip: _____

Allergies: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Cohabitating ☐ Widowed

Spouse/Partner Name: _____ Phone: _____ Date of Birth ____/____/____

Partner or Guardian if under 18 years of age: _____

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

Referred By: _____

Method of Payment: ☐ Insurance ☐ Cash ☐ Both

Primary Physician: _____ Phone #:_____

Date of last physical exam: ____/____/____

Current Psychologist: ☐ Yes ☐ No If yes: Name/Phone _____

Current Therapist: ☐ Yes ☐ No If yes: Name/Phone _____

What are you seeking help with? _____

What are your treatment goals right now? _____

Pathways
the power to change

Name:_____

Personal Medical History

Height: ____ ft. ____ in. Weight: _____ lbs. Average Blood Pressure: ____/____

Any significant childhood illnesses/problems: _____

Any medical problems that other doctors have diagnosed:

1. _____
2. _____
3. _____
4. _____
5. _____

Surgeries:

Year	Reason	Hospital

Other Medical or Psychiatric Hospitalizations:

Year	Reason	Hospital

Any Psychiatric or Substance Abuse Outpatient Treatment:

Year	Reason	Hospital/Program

Pathways
the power to change

Name: _____

Client Information and Release (Personal History)

List your prescribed and over-the-counter drugs, such as vitamins and inhalers:

Drug	Strength	Frequency Taken

Allergies to Medications:

Drug	Type of Reaction

Have you ever had an EKG? ☐ Yes ☐ No If yes, when: _____

The EKG was: ☐ Normal ☐ Abnormal ☐ Unknown

Please check if you have, or have had any symptoms or problems in the following areas to a **significant** degree and briefly explain:

☐Cold/Flu	☐ADD/ADHD	☐Bladder/Prostate	☐Anxiety/PTSD
☐Epilepsy/Seizures	☐Claustrophobia	☐Vertigo	☐Peripheral Neuropathy
☐Skin/Herpes	☐Immune System	☐Infections	☐Headaches/Migraine
☐Depression	☐Cancer	☐Dizziness	☐Cushing's Syndrome
☐Anti-Depressants	☐Insomnia	☐Ears	☐Sexual Disorders
☐Stimulants	☐Fibromyalgia	☐Eye Injury	☐Eating Disorders
☐Marijuana	☐Intestinal/Bowel	☐Asthma	☐Cerebral Palsy
☐Tobacco	☐Brain Injury	☐Autism	☐Multiple Sclerosis
☐Alcohol	☐Heart Disease	☐Stress	☐Energy Level
☐Heroin	☐Fatigue	☐Bipolar Disorder	☐Weight
☐Cocaine	☐Back Pain	☐Down Syndrome	☐Other pain/discomfort
☐Benzodiazepines	☐Diabetes	☐Alzheimer's	☐Hormone Imbalance

Explain:

_____

_____

Pathways
the power to change

Name: _____

Client Information and Release (Family History)

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	☐M ☐F	
Mother				☐M ☐F	
Sibling	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	
	☐M ☐F		Grandmother *Maternal*		
	☐M ☐F		Grandfather *Maternal*		
	☐M ☐F		Grandmother *Paternal*		
	☐M ☐F		Grandfather *Paternal*		

Social History

Where do you live? _____
Who lives with you? _____
Highest level of education? _____
What is your current job? _____
What jobs have you had in the past? _____
_____
Are you married? ☐ Yes ☐ No If so, for how long? _____
Have you been married in the past? ☐ Yes ☐ No # of times? _____
Do you have children? ☐ Yes ☐ No If so, how many? _____ Ages? ___,___,___,___
What do you do in your free time to relax? _____
Do you have religious beliefs? ☐ Yes ☐ No How Important are those beliefs? _____

Pathways
the power to change

Name: _____

Client Information and Release (Health & Safety 1)

Note: All questions contained in this questionnaire are optional and will be kept strictly confidential

Exercise Level	☐No Exercise				
	☐Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 min.)				
Diet	Are you currently dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# Of meals you eat in an average day?				
	Rank sugar intake	☐ High	☐ Medium	☐ Low	
	Rank fat intake	☐ High	☐ Medium	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda/Cola	
	# Of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to “binge” drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No

Continued on next page

Pathways
the power to change

Name: _____

Client Information and Release (Health & Safety 2)

Note: All questions contained in this questionnaire are optional and will be kept strictly confidential

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐Cigarettes - # Packs ___/day	☐Chew - #___/day	☐Pipe - #___/day	☐Cigar - #___/day	
	Total Number of Years:	Or Year Quit:			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for pregnancy?			☐ Yes	☐ No
	If not trying for pregnancy list contraceptive used, if any:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider (Pathways) about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in the country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issues with your provider (Pathways)?			☐ Yes	☐ No

Pathways
the power to change

Client Information and Release (Consent)

I acknowledge that I have received, have read (or have had read to me), and now understand the information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the recovery oriented system of care provided by this agency, its' contractors, and/or its' employees. I understand that developing a treatment plan and regularly reviewing the work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of medical treatment, behavioral health, counseling, recovery coaching, case management, supportive services, mentoring or of any other procedures provided by this agency, its' contractors or employees.

I am aware that I may stop any course of treatment this agency is providing at any time. The only thing I will still be responsible for is paying for the services I have already received, any outstanding co-payments, or for missed appointments that I have not cancelled within 24 (twenty four) hours in advance.

I know that I must call to cancel an appointment at least 24 (twenty four) hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment. I also know that I will have to pay for missed sessions incurred before I have made arrangements to cancel.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), costs, date(s), and providers of any services, psycho-education, recovery coaching or medical treatments that I receive if I am submitting services for insurance payment. I understand that I will be responsible for the cost of all services provided if the insurance denies my claims or coverage for the services at PATHWAYS. I understand that if payment for services I receive is not made, the therapist or other medical providers may stop my treatment. I understand that if my account becomes delinquent it will be sent to a collection agency. I will be responsible for the collection agency fees.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Client Signature (or person acting for Client) Date

_____ _____

Printed name Relationship (if not Client)

Pathways
the power to change

Transportation Liability Release Form

In consideration for being a passenger in a PATHWAYS Employee's personal vehicle or another vehicle that is driven by a PATHWAYS Employee, I hereby RELEASE, WAIVE, DISCHARGE and will not sue PATHWAYS dba Pathways Real Life Recovery in the State of Utah.

To the best of my knowledge, I am fully aware of the risks and hazards associated with vehicular travel. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained by me, or any loss or damage to personal property owned by me, as a result of being a passenger in these vehicles, WHETHER CAUSE BY NEGLIGENCE OR ACCIDENT or otherwise.

I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS THE LEASES from any loss, liability, damage or costs, including court costs and attorneys' fees that may incur WHILE BEING A PASSENGER IN SAID VEHICLE, WHETHER CAUSE BY NEGLIGENCE OR ACCIDENT or otherwise.

It is my express intent that this release and hold harmless agreement shall bind the members of my family and spouse (if any), if I am alive, and my heirs, assigns, and personal representatives, if I am not alive, and shall be deemed as a RELEASE, WAIVER, DISCHARGE, AND COVENEANT NOT TO SUE the above named RELEASES. I hereby further agree that this waiver of liability and hold harmless agreement shall not be constructed in accordance with the laws of the State of Utah.

I UNDERSTAND THAT THE OWNER OR OWNER'S INSURANCE WILL NOT BE RESPONSIBLE FOR ANY MEDICAL COSTS ASSOCIATED WITH AN INJURY I MAY SUSTAIN WHILE BEING A PASSENGER IN SAID VEHICLE. Any such coverage is at the benevolence and sole discretion of PATHWAYS.

IN SIGNING THIS REALEASE, I ACKNWLEDGE AND REPRESETN THAT I have read the above waiver of liability and hold harmless agreement, understand it, and sign it voluntarily as my own free act and deed; no oral representations, statements or inducements, apart from the aforementioned written agreement, have been made. I am at least 18 (eighteen) years of age and fully competent and I execute this release for full, adequate, and complete consideration fully intending to be bound by same.

IN WITNESS WHEROF, I have hereunto set my hand this _____ day of _____ 20_____.

_____	_____	_____
Client Signature	Client Printed Name	Date
_____	_____	_____
Pathways Staff Signature	Pathways Staff Printed Name	Date

Pathways
the power to change

Client/Consumer Rights

As a client of Pathways, you have the right to:

-Privacy of information, your clinical records will not be released without a signed release of information designating where the information should be sent.

-If your treatment is involuntarily terminated, you have the right to appeal this decision and a meeting will be scheduled with the clinical director to discuss your reinstatement. The possible reasons for involuntary termination of care includes, but is not limited to: probation/parole violations, assaulting another client/consumer or therapist, missing two appointments without notice.

-Freedom from potential harm or acts of violence from other clients/consumers and staff.

-24 hour cancellation. If you do not cancel your scheduled appointment at least 24 (twenty four) hours in advance, you will be charged $50.00 for that missed appointment. Payable by cash or check.

-Know the cost of your therapy sessions. If this has not been addressed prior to your intake packet completion, please ask for a copy of our financial agreement.

-File a complaint or grievance about your therapist with the program director or CEO of the company, or file a grievance with the state licensing board.

-Freedom from discrimination.

-To be treated with dignity and respect.

-Smoke outside the facility, at least 25 feet away from the entryway of Pathways.

-If you are court ordered into Pathways, we have a responsibility to the court. Non-compliance or failure to follow through with court orders will be reported to the court.

I have read the above rights and understand what my rights are as a client/consumer of Pathways. If I had any questions about my rights, they were clearly explained to me.

_____ _____

Signature Date

_____ _____

Witness Date

Pathways Mandatory Participation

As a client participating with Pathways Real Life Recovery Program, you will be required to the following:

Adults (over 18 years of age) will be required to attend groups located at the Pathways office on the following nights:

Monday: Family Night from 6:30pm to 8:30pm
Wednesday: Group Night from 6:30pm to 8:30pm

The program also requires at least 2 drug/alcohol testing UA's per week.

Adolescents (under 18 years of age) are required to take 2-3 drug/alcohol testing UA's weekly.

I acknowledge and agree to these terms of service with Pathways Real Life Recovery.

_____ _____
Client Date

_____ _____
Parent/Guardian of Minor Date

The address for all our Group Nights is:

1098 W. South Jordan Parkway, Suite 108
South Jordan, UT 84092
Office Number: 801-277-7591

Pathways
the power to change

Name: _____

Client Family Demographics For Family Night Groups

Please list all immediate family members by name along with their date of birth and address.

Name	Relationship	Date of Birth	Address

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name: _____

Financial Contract and Fee Agreement (Page 1)

This Agreement ("Agreement") memorializes the payment obligations undertaken by _____ (hereinafter, the "Responsible Party"), to PATHWAYS and its subsidiaries (hereinafter, "PATHWAYS"), for the treatment and other services provided by PATHWAYS to _____ (hereinafter "Client"), and is executed and effective as of this _____ day of _____, 20____. In the event that Client is a minor or is subject to legal guardianship, the parent/legal guardian of Client is _____, and will hereinafter be referred to as "Client".

1. FINANCIAL INFORMATION: The Responsible Party will provide financial information regarding ability to pay for treatment services and/or room and board. _____
   Initials

2. THIRD PARTY PAYER: PATHWAYS will make every reasonable effort to bill any appropriate and pre-arranged third party payers, such as government entities, insurance. In the case of clients covered by private medical insurance carriers, PATHWAYS requires the Responsible Party to render payment to PATHWAYS for services provided and to file any claims for reimbursement with their medical insurance carrier. Responsible Party understands it will be responsible for the portion of fees not covered or paid by the insurance company. This includes any deductibles, co-payments, or charges for services deemed unallowable by the insurance carrier. Responsible Party understands it must provide correct and complete insurance information upon admissions to PATHWAYS. Responsible Party agrees that, until the necessary information is provided, and, where the Client is covered by private medical insurance, until reimbursement is received from such insurer, Responsible Party is responsible for payment of any services provided by PATHWAYS. Responsible Party also understands that it is ultimately responsible to obtain any pre-authorization that may be required by any relevant insurance company/third party payer. Additionally, an insurance policy is a contract between the insured and the insurance company. PATHWAYS is not a party to that contract. Furthermore, the contract for services provided by PATHWAYS is between the Client/Responsible Party and PATHWAYS. PATHWAYS is, therefore, not under any obligation to attempt collection from the insurance carrier before collecting from Responsible Party. If the insurance company has not paid the account in full within 45 days, the balance due will be transferred to the Responsible Party's account and that party will be notified of such transfer. This amount will be due and payable in full at the time of the transfer. NOTE: Please be aware that insurance plans vary as to the nature and extent of covered services. Therefore, some, and perhaps all, of the services provided by PATHWAYS may be non-covered services under the responsible party's third party payer's plan. Responsible Party understands it is solely responsible for determining whether coverage is available. _____
   Initials

Continued on next page

Name: _____

Financial Contract and Fee Agreement (Page 2)

3. RELEASE OF INFORMATION: Client, by signing below, gives consent to PATHWAYS to share any personal medical information with any and all respective third party payers for the purposes of securing funding and/or any utilization review or audit conducted by agents of the third party payer.

   _____
   Initials

4. PROMISE TO PAY: Responsible Party understands that by signing below, it is promising to pay all charges and reimbursements, including co-pays, accrued to PATHWAYS on Client's behalf. Responsible Party understands the minimum payment stated shall continue to be due and payable at the beginning of each month until all amounts accrued for services performed by Contractor under this agreement shall be paid in full. Payment of the charges and fees is considered part of the treatment process. Responsible Party understands that any payments made *will not be refunded* under any circumstances. Responsible Party and Client agree services may be terminated immediately at any time the account is 60 days in arrears. Responsible Party further agrees to satisfactorily make arrangements with the PATHWAYS of Utah accounting office to make payments, etc. if the account should become delinquent.

   _____
   Initials

5. DELINQUENCY, APPEAL, AND COLLECTION: In the event the account becomes delinquent (as defined in the preceding paragraph), Responsible Party has 60 days to notify the PATHWAYS of Utah accounting office of any desire to appeal for reduction in co-pays, charges, etc. If Responsible Party does not follow the above procedures or respond after good faith attempts by PATHWAYS of Utah to contact Responsible Party, the account may be turned over to an attorney or collection agency for collection. In the event the account is turned over to collection, Responsible Party shall be liable for reasonable collection costs, including attorneys' fees, whether or not litigation is commenced. PATHWAYS reserves the right to modify collection efforts and time schedules for any account deemed, in its judgement, to warrant such treatment. Such adjustments may include, but are not limited to placing accounts with attorneys or collection agencies, or pursuit of other methods of legal recourse to insure collection of accounts. Any lawsuit arising from or relating to this Agreement shall be commenced exclusively in the state or federal courts situated in the State of Utah, and the parties hereto irrevocably consent to the jurisdiction of such courts. This Agreement shall be governed by and construed in accordance with Utah law.

   _____
   Initials

Continued on next page

Name: _____

Financial Contract and Fee Agreement (Page 3)

6. CO-PAYMENTS: If Client is admitted with funding assistance from a third party payer, Responsible Party understands it may be required to make a co-payment for treatment services rendered. The amount of the co-payment is based on those established by the relevant insurance company. If you are unsure as to the amount of your possible co-pay amount, please seek that information from the PATHWAYS of Utah accounting office. _____
   Initials

7. PUBLISHED RATES: Below are the published rates. Unless otherwise specified in the following OTHER PAYMENT section, Responsible Party understands it will be required to the published rates for treatment services rendered. The amount of the published rates is based upon those established with/by the relevant insurance company.

Social Detoxification Program:	$2,000 per day
General Outpatient (Individual/Group)	$195 per hour
Day Treatment Program (PHP)	$23,500 per 100 hours
Intensive Outpatient (IOP)	$23,500 per 100 hours

I, _____, the Responsible Party, agree to pay the entire balance accrued for all the services provided by PATHWAYS. _____
Initials

Continued on next page

Pathways
the power to change

Name: _____

Financial Contract and Fee Agreement (Page 4)

8. OTHER PAYMENT: In some circumstances, such as in the case of insurance failing to pay or the Responsible Party paying "out of pocket", the following payments shall apply as approved by the Program Director or CEO. In some cases, the Responsible Party shall receive an individualized rate, which will become part of this Agreement.

Social Detoxification	$2,000 per day
Transitional Living Program	$1,750 per month
Outpatient Therapy	$195 per hour
Day Treatment	$195 per hour

I, _____, the Responsible Party, agree to pay the entire balance, according to the above OTHER PAYMENT RATES or the attached Rate Sheet, accrued for all services provided by PATHWAYS. _____
Initials

9. ADDRESS: Responsible Party resides at the following address:
_____
_____
_____

Responsible Party agrees to contact PATHWAYS with an updated billing address within 30 (thirty) days of any change.

The undersigned acknowledge that they have read the foregoing and agree to all contingencies and penalties therein, and are fully aware of the legal consequences of signing this document.

_____ _____
Responsible Party Signature Date

_____ _____
Co-Responsible Party Signature Date

_____ _____
Client Signature Date

_____ _____
Witness/Staff Date

Name: _____

Financial Contract and Fee Agreement (Page 5)

I, _____, agree to pay the entire balance accrued for all services provided by PATHWAYS.

_____ _____

Responsible Party Date

I agree to the following payment fee schedule:

☐ Amount: _____ Date: _____

Amount: _____ Date: _____

Amount: _____ Date: _____

Amount: _____ Date: _____

Amount: _____ Date: _____

OR

☐ Amount: _____ per month until balance paid in full.

Payments not made for the above dates/schedules may result in a $25.00 late fee and a 5% interest rate will be applied to the outstanding balance.

_____ _____

Responsible Party Signature Date

_____ _____

PATHWAYS WITNESS Date

Pathways
the power to change

Name: _____

Authorization Form for Release of Confidential Information (Page 1)

(Health Information Portability Accountability Act (HIPAA) Public Law 104-191, Privacy Rule 42 CFR Part 160 and subparts A & E of Part 164, Enforcement Rule 42 CFR Part subparts C, D, & E)

I, _____, hereby authorize Pathways Real Life Recovery as indicated below:

Name of Person and/or Agency: _____
Complete Address: _____
Phone/Fax Number: _____
Start/Stop Date: ____/____/____ to ____/____/____ Initial & Date: _____ ____/____/____

Name of Person and/or Agency: _____
Complete Address: _____
Phone/Fax Number: _____
Start/Stop Date: ____/____/____ to ____/____/____ Initial & Date: _____ ____/____/____

Name of Person and/or Agency: _____
Complete Address: _____
Phone/Fax Number: _____
Start/Stop Date: ____/____/____ to ____/____/____ Initial & Date: _____ ____/____/____

As it pertains to information contained in the Client record of:

_____	____/____/____	_____
Clients Name	Date of Birth	Complete Address

The following components of my medical record: (please fax to 801-277-7593)
To be disclosed, specific components being requested must be check individually:

☐Alcoholism/Drug Abuse Treatment Records ☐Mental Health Treatment Records ☐Progress Notes
☐Lab Reports ☐Psychotherapy Notes ☐Biopsychosocial History ☐Other: _____

The purpose(s) of the authorization is/are:

☐Patient Request ☐Facility Request ☐Treatment Planning ☐Necessary for Evaluation
☐Referral ☐Other (specify): _____

Continued on next page

Name: _____

Authorization Form for Release of Confidential Information (Page 2)

I understand that information used or disclosed pursuant to this authorization may not be redisclosed by any recipient. Initial _____

I understand that this authorization is valid for 120 days unless revoked prior to that date. Initial _____

I understand that I may revoke this authorization at any time by giving written notice to Pathways of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the Pathways office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate after 120 days.

_____ _____
Client Signature Date

_____ _____
Clients Legal Representative Signature Date

_____ _____
Witness Signature Date

Pathways Real Life Recovery
1098 W. South Jordan Parkway #108
South Jordan, UT 84092
Phone: 801-277-7591
Fax: 801-277-7593

Name: _____

Durable Power of Attorney (Page 1)

KNOW ALL MEN BY THESE PRESENTS; this power of attorney is intended to constitute a Durable Power of Attorney under Title 26, Chapter 3, Section 7 of the Utah Statutes, THAT
I, _____, (Client name)(the "Principal") having an address at 1098 W. South Jordan Parkway #108, South Jordan, UT 84092 with insurance ID# _____ hereby make, constitute, and appoint each and all of:

Pathways Real Life Recovery

My true and lawful attorney-in-fact TO ACT SEVERALLY in my name, place, and stead to do and perform all and every act and thing whatsoever requisite and necessary in any way which I could or might do, if personally present, with respect to obtaining payment end or reimbursement for hospital, medical, chemical dependency treatment, and other health care services rendered to the Principal by *Pathways* whose address is *1098 W. South Jordan Parkway #108, South Jordan, UT 84092* and any of its affiliates, including, but not limited to obtaining insurance, making of claims against insurers, or other third-party payers. Instituting and prosecuting and/or defending litigation, arbitration and/or other dispute resolution proceedings, compromise and/or statement of claims and/or disputes, obtaining and/or releasing records, reports, and statements, including, but not limited to, any and all medical reports from prior treatment providers, subject to complying with federal confidentiality rules under 42 CFR Part 2, as well as all other acts which may be helpful and appropriate to the accomplishment of such purposes, for the ultimate objective of *Pathways.* Such additional acts shall include, without limitation, endorsing any draft, check, or other negotiable instrument representing insurance or other third party benefits received by or on behalf of the Principals mailing address has temporarily changed, the filing of all documents and forms which may be necessary or appropriate to maintain continued or extended health care insurance, including, by not limited to, continuation of coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), 29 U.S.C. Section 1161 Et.seq.

Each of my said attorneys shall have full and unqualified authority to my attorney(s)-in-fact to delegate any or all of the foregoing powers to any person or persons whom my attorney(s)-in-fact select, to the maximum extent from time not forbidden by law.

The Durable Power of Attorney shall not be affected by the subsequent disability, incapacity, or incompetence of the Principal except as provided in Title 14, Article 5 of the Utah Statutes, and other specifically applicable law.

Continued on next page

Name: _____

Durable Power of Attorney (Page 2)

To induce any third party to act hereunder, I agree that, as against third parties, I will not question the sufficiency of any other document executed by my attorney(s)-in-fact pursuant to this Power of Attorney. Any third party receiving a duly executed copy or facsimile of this Power of Attorney may act in reliance hereon, and that revocation or termination hereof shall be ineffective as to such third party unless and until receipt of actual notice of knowledge thereof, and I, for myself and my heirs, executors, legal representatives and assigns, agree to indemnify and hold such third party harmless from and against any and all claims that may arise by reason of reliance upon the Durable Power of Attorney. By signing this document I confirm that I have read and understand all terms of this document, which is being initiated without duress.

_____
Principal Signature

_____
Print Name

_____
Insured Signature

_____
Print Name

_____
Witness Signature & Print

_____
Witness Signature & Print

_____
Effective Date

Submit Save Print