Spencer Recovery Centers

State of California – Health and Welfare Agency

ADMISSION AGREEMENT

Spencer Recovery Centers	Residential
Name of Facility	Type of Facility
1316 South Coast Hwy, Laguna Beach, CA 92651	(949) 376-3705
Address	Telephone

Name of Client	Social Security #	Birth Date

Description of Services

1. BASIC GENERAL SERVICES:
   a. Lodging: ___ private ___ semi-private
   b. Food Services:
      1. Three nutritious meals daily and between meals nourishment or snack
      2. Special diets if prescribed by a physician
   c. Laundry Facility
   d. General cleaning of Client's room
   e. Comfortable and suitable bed including fresh linen weekly or more often if required.
   f. Plan, arrange and /or provide for transportation to medical and dental appointments.
   g. Plan, arrange and/or provide transportation for **emergency medical treatment**. Client is responsible for payment to the provider of emergency medical transportation.
   h. Planned activity program including arrangements for utilization of available community resources.
   i. Notification to family and any other appropriate person/agency of Client's needs.
   j. Services to be provided include: detox (if ordered by medical director); a minimum of 20 hours per week of individual therapy sessions and/or group sessions which include; multi-family, education, activity and process groups; recreational therapy and one year of aftercare groups.

2. BASIC PERSONAL SERVICES:
   a. Continuous observation, care and supervision, as required.
   b. Ensuring that bathing and personal hygiene needs are met, as required.
   c. Ensuring that necessary medical and dental needs are met, as required.
   d. Ensuring that prescribed medications are taken in accordance with the physician's instructions unless prohibited by law or regulations.
   e. Provide bedside care for minor temporary illnesses.

3. FEES FOR SERVICES:

   ____ The cash rate for basic services is $17,700.00 for a 28 day treatment program.

   ____ The cash rate for basic services is $_____ for a _____ day treatment program.

****Please Note: Any use or possession of mind/mood altering chemicals or paraphernalia is strictly prohibited and grounds for immediate discharge. In this case, the "Fees for Services" quoted here are non-refundable, and Section 6, "Early Termination" will no longer apply.**

____ Insurance will be billed at the retail rate of $1,300 per diem ($1,500 per diem for detox). Any contractual discounts will be applied at time of payment from insurance company. Verification of benefits is not a guarantee of payment; therefore, Client agrees to pay all costs incurred while in treatment that are not paid by insurance.

Treatment costs will continue at the basic monthly rate identified above after the 28 days are expired, until a new agreement is signed.

By signing this agreement, I give consent to Spencer Recovery Centers to send any remaining unpaid balance to a collection agency of their choice if the account becomes delinquent.

4. ADDITIONAL SERVICES:

a. The following additional services may be provided:

Service	**Time/Intervals**	**Rate**
Detoxification Services	Upon admission	$3,700.00
Drug screen	As needed	$25.00
Medications	As needed	R & C
Follow-up doctor visit	As needed	$150.00
Additional Counseling Sessions	As needed	$150.00
Psychiatric Services	As needed	$2700.00
Grace Track	As needed	$1700.00
Coaching, per day	As needed	$1,000.00

b. Client is responsible for payment to the provider for all additional services provided.

5. EVICTION PROCEDURES:

The licensee/administrator of the facility may evict the Client for one or more of the following reasons:

a. Nonpayment of the rate for basic services within 10 days of the due date.
b. Failure of the Client to comply with state or local law after receiving written notice of any alleged violation.
c. Failure of the Client to comply with the written general policies of the facility, which are for the purpose of making it possible for the clients to live together. (See attached rules)
d. Inability of licensee to meet the Client's needs. Based upon a reassessment of the Client's needs, conducted pursuant to applicable regulations, the licensee/ administrator of the facility and the person who performs the assessment determine that the facility is not appropriate for the Client and the Client has been given the opportunity to relocate.
e. If the Client is engaging in behavior which is a threat to the mental and/or physical health or safety of himself/herself or to others in the facility.
f. Change of use of the facility.

6. EARLY TERMINATION:

Client acknowledges that by agreeing to treatment at this facility, the facility will reserve space and resources for the Client's benefit during the anticipated term of Client's stay. If Client chooses to leave the facility prematurely, or is evicted under other provisions in this Agreement for inappropriate behavior, then the Client acknowledges that those resources will not be utilized and that it will take some time for a new client to be admitted. The facility will suffer monetary loss due to the under-utilization of its resources. The amount is difficult to quantify and predict on a case to case basis. Therefore, Client agrees that if Client leaves the facility prematurely for any reason that the cost of services will be prorated for the actual number of days Client has been at the facility as follows: days 1-5 will be charged at $1720 per day; days 6-12 will be charged at $1300 per day; and all other remaining days will be charged at $900 per day, but the total cost will not exceed the original cash rate quoted. This will compensate the Facility for the losses it will suffer through under-utilization of its resources. Client agrees that

this is a reasonable estimate of the losses Facility may suffer and is a reasonable liquidated damage and not a penalty.

7. REFUND POLICY:
Any prorated amount will be submitted for processing within 30 days of discharge.

8. I have been informed that the cost of treatment quoted includes the specified treatment and room and board. Any ancillary services provided are non-inclusive and will be an additional cost. All ancillary services will be charged at reasonable and customary rates and are payable at time of service.

9. If rates are increased, Client or authorized representative will be given at least 30 days written notice of the change.

10. The facility will not be responsible for any cash resources, valuables or personal property brought into the facility.

11. I, _____, will:
(Name of Client or authorized representative)
    a. Pay the basic monthly rate:
    ___ in advance
    ___ by insurance, or in arrears if insurance does not pay
    b. Cooperate with the general policies of the facility that make it possible for the clients to live together.
    c. Not bring medications, special foods, or beverages into the facility without the knowledge of the administrator.
    d. Not be destructive of the property of the facility or other clients. The Client will be held financially responsible for any damages to the property of Spencer Recovery Centers.

My signature below as "Client or Authorized Representative" indicates that I have read, or had read and explained to me, the provisions of this agreement and enter into this agreement voluntarily.

PARTIES TO THIS AGREEMENT:

_____

CLIENT SIGNATURE Date

_____

AUTHORIZED REPRESENTATIVE Date

_____

SRC REPRESENTATIVE/WITNESS Date

Admission agreements shall be completed and signed in duplicate. One copy to be retained by the facility and one copy to be given to the Client or authorized representative.

My signature indicates that I have received a copy of this agreement _____.
CLIENT SIGNATURE