Brain Injury Alliance COLORADO

2020 Participant Application

Section One: Tell Us About You

Applicant's Name: _____ Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Emergency Phone: _____

Email: _____

DOB: ____/____/____ Male: _____ Female: _____ Height: _____ Weight: _____

Which program are you applying for?

Indicate your **1st and 2nd choice** (scheduling problems, let Linda know (303) 562-0401).

Brain Injury Alliance of Colorado Programs 2020

___ **Frozen Assets**	January 6 – 10	$1390
___ **Challenge by Choice**	June 7 – 12	$1890
___ **Challenge by Choice**	July 12 – 17	$1890
___ **Challenge by Choice**	August 2 – 7	$1890
___ **Challenge by Choice**	August 16 – 21	$1890
___ **Canyon Canoe Trip**	August 31 – 4	$970
___ **Creative Minds**	September 11 – 14	$990
___ **BIA Road Trip**	September 6 – 19	$1,165

Programs held at Breckenridge Outdoor Education Center

Note: All participants must include a $100 registration fee with the application, which is non-refundable. Upon acceptance of the Participant's Application, ½ of the participant fees are due. The remainder is due 30 days prior to the program's start date.

Applicant's Name: _____Date:_____/_____/_____

Guardian:

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Other Phone: _____ Email: _____

Other Emergency Contacts:

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____

Conditions that we cannot serve: Insulin dependent diabetes, uncontrolled seizures, no seizures for at least 6 months (which needs to be signed off and validated by a physician), active or worsening pressure ulcers, uncontrolled BP (which might put the participant at a greater fall risk or cardiac risk).

Current Medical Insurance? ☐ Yes ☐ No Name on card: _____
Group #: _____ Plan #: _____ Member Services Phone #: _____
Current Physician:_____ Phone #: _____

Your Injury: Date of your injury: _____ How old were you? _____
Tell us about your injury: _____
_____.

Have you ever sustained a brain injury in the workplace? ☐ Yes ☐ No
If yes, did you receive workers compensation benefits for that injury? ☐ Yes ☐ No

Mobility: ☐ Walk Independently ☐ Manual Wheelchair ☐ Electric ☐ Wheelchair ☐ Walker ☐ Cane ☐ Crutches Explain: _____

If in a wheelchair:

Use the chair: ☐ Always ☐ Just when fatigued ☐ Just outside ☐ Not at home, just program ☐ Not at program
Operate the wheelchair independently: ☐ Yes ☐ No Explain: _____
Transfers: ☐ No assist ☐ Total assist ☐ Pivot with spotter Explain: _____
Weight shifts: ☐ None ☐ Yes, required How often: _____ Assistance: _____ Props: _____
Balance concerns: ☐ Yes ☐ No Explain: _____
Walking concerns: ☐ Yes ☐ No Explain: _____

Applicant's Name: _____Date:_____/_____/_____

Require assistance on rough, uneven terrain: ☐ Yes ☐ No Explain: _____

How far can you walk? _____

Can you climb up and down stairs independently: ☐ Yes ☐ No Explain: _____

Other adaptive devices: ☐ None ☐ Night Braces/AFO's ☐ Prosthesis ☐ Helmet ☐ Glasses/Contacts ☐ Hearing Aid ☐ Dentures Explain: _____

Communication: ☐ Speaks ☐ Sign Language ☐ Communication Board ☐ Device ☐ Gestures Explain: _____

Can you understand what is said to you? ☐ Yes ☐ No Explain: _____

Can you express your needs? ☐ Yes ☐ No Explain: _____

Do you KNOW sign language? ☐ Yes ☐ No Explain: _____

Speech: ☐ Normal ☐ Mildly affected ☐ Moderately affected ☐ Severely affected ☐ Few words ☐ Non-verbal

Hearing: ☐ Normal ☐ Hard of hearing ☐ Hearing aid ☐ Sensitive to excessive noise

Vision: ☐ Normal ☐ Legally Blind ☐ Total Loss ☐ No peripheral vision ☐ Wears glasses ☐ Contacts

Are you sensitive to light? ☐ Yes ☐ No Explain: _____

Behavior:

Memory: ☐ OK ☐ Mid short-term loss ☐ Severe short-term loss ☐ Extreme STM loss Explain: _____

In a new situation you: ☐ Get lost ☐ Lose belongings ☐ Run away ☐ Wander-off

Anger Issues: ☐ None ☐ Mild ☐ Sometimes ☐ Severe ☐ Often What causes it? _____

Lose **verbal** control: ☐ Yes ☐ No Explain: _____

Lose **physical** control: ☐ Yes ☐ No Explain: _____

What helps calm you down: _____

Frustration: ☐ Never ☐ Sometimes ☐ Occasionally ☐ Often ☐ Always Cause: _____

Depression: ☐ Never ☐ Sometimes ☐ Occasionally ☐ Always Controlled by meds: _____

Paranoia: ☐ Never ☐ Sometimes ☐ Occasionally ☐ Always Controlled by meds: _____

Fears: _____

Are you currently receiving Psychotherapy? ☐ Yes ☐ No If yes: Dr. _____ Phone #_____

Personal Hygiene:

Washing/Showering: ☐ No assist ☐ Partial assist ☐ Total assist ☐ Shower chair ☐ Just needs a shower bar

Assistance with: ☐ Hair ☐ Teeth ☐ Shaving Explain: _____

Dressing: ☐ No assist ☐ Partial assist ☐ Total assist Explain: _____

Shower time: _____ Dressing time: _____

For women: Do you need assistance with feminine products? ☐ Yes ☐ No Uses: ☐ Pads ☐ Tampons

Applicant's Name: _____ **Date:**_____/_____/_____

Smoke: ☐ Yes ☐ No How much? _____

What is your typical hygiene routine: A.M.: _____ P.M.: _____

Toileting: ☐ No assist ☐ Partial assist ☐ Total assist Explain: _____

Bladder needs: ☐ None ☐ Incontinent ☐ Needs reminders ☐ Needs to go very often
Explain: _____

Bowel needs: ☐ None ☐ Incontinent ☐ Needs reminders ☐ Chronic diarrhea
Explain: _____

Toileting schedule: _____

Behavior related to disruptive toilet habits: _____

Bowel routine time: _____

Aids: ☐ None ☐ Urinal ☐ P.M. urinal ☐ Catheter ☐ P.M. catheter ☐ Toilet chair

Diapers: ☐ P.M. diaper ☐ Ostomy bag ☐ Bedpan ☐ Suppositories ☐ Enema

Sleep Routine:

Require a nap: ☐ Never ☐ Sometimes ☐ Once a day ☐ Only when very active

Feel fatigued: ☐ Feel fine ☐ Not usually ☐ Sometimes ☐ Only occasionally ☐ All the time

Trouble sleeping: ☐ Yes ☐ No ☐ If noisy ☐ Need light on ☐ Need total dark ☐ New place

Do you require a bed railing? ☐ Yes ☐ No

Need to be awakened or turned at night: ☐ Yes ☐ No Explain: _____

Usually wake up: _____ Usually go to bed: _____

Meals: ☐ No assist ☐ Partial assist ☐ Total assist

Food must be: ☐ Cooled down ☐ Cut-up ☐ Mashed ☐ Pureed ☐ Liquefied
Explain: _____

Aids: ☐ Straw ☐ Feeding Tube Adaptive utensils: _____

Eating speed: ☐ Average speed ☐ Fast ☐ Slow ☐ Very slow

Eating or swallowing concerns? _____

Religious dietary needs: ☐ Yes ☐ No Explain: _____

Allergies: ☐ Yes ☐ No Explain: _____

Vegetarian: ☐ Yes ☐ No Explain: _____

Dislikes: ☐ Yes ☐ No Explain: _____

Applicant's Name: _____Date:_____/_____/_____

About Me!

My hopes and aspirations:

_____

_____

_____.

My struggles:

_____

_____

_____.

My strengths:

_____

_____

_____.

How I spend my leisure and play time:

_____

_____

_____

_____.

When you're not at the program:

Live: ☐ Own home ☐ With family ☐ Apt. alone ☐ Apt. with roommate ☐ Assisted living

Day Program: ☐ Yes ☐ No Which one? _____

School: ☐ Yes ☐ No Which one? _____

How do you get around? ☐ Walk ☐ Bike ☐ Drive ☐ Bus ☐ Special transit ☐ Arranged rides ☐ Wheelchair

Brain Injury Alliance COLORADO

Participant Medical Form

Applicant's Name: _____ Date: ____/____/____

Section Two: For Your Doctor to Complete

This Medical Form must be completed by the participant's doctor once annually.

Medical History:

1. Chronic health problems (e.g. asthma, pressure sores, cough, constipation) and treatments of which the medical staff should be aware: _____
   _____.

2. Applicant a carrier of Hepatitis B or has he/she been exposed to Hepatitis B: ☐ Yes ☐ No
   If yes, was a lab test conducted to determine the presence of antibodies? ☐ Yes ☐ No
   Were antibodies present? ☐ Yes ☐ No Physician's initials _____

3. Applicant a carrier of any other infectious or contagious condition: ☐ Yes ☐ No
   Explain: _____

4. Allergies: ☐ Yes ☐ No Describe: _____

5. Seizures: ☐ Yes ☐ No Type: _____
   Date of the last one: ____/____/____
   Are they controlled by medication? ☐ Yes ☐ No What: _____
   Can applicant tell if one is coming on? ☐ Yes ☐ No How: _____

6. Vitals: ☐ Heart problems ☐ Heart murmur ☐ Irregular heart beat ☐ Blood pressure concerns
   Explain: _____
   Problems at higher elevation: ☐ Yes ☐ No Explain: _____

7. Applicant's immunization records up-to-date and complete: ☐ Yes ☐ No
   Date of last tetanus shot: ____/____/____

Applicant's Name: _____ Date:_____/_____/_____

Medications: List all medications currently taken by the applicant. Please attach additional sheet(s) if needed.

Med. Name	Dosage Times	Total/Day	Reason Prescribed
1.			
2.			
3.			

Describe how the applicant best takes the medication(s).

Over the counter ANYTHING: _____

_____ Doses: _____

Vitamins and Herbs: _____

_____ Doses: _____

Restrictions:

1. Has the applicant been hospitalized or treated in an emergency room recently? ☐ Yes ☐ No
   If yes, please explain _____
2. Physical conditions, past operations or injuries which might restrict program activity? ☐ Yes ☐ No
   Explain restrictions _____
3. Pulse Oxide Range _____ to _____

Physician Signature: _____ Date:_____/_____/_____

Physician's Name (Please Print):_____

Office Phone: _____ Emergency Phone: _____

Brain Injury Alliance COLORADO

Send your completed form with PHYSICIAN'S SIGNATURE to:

Linda Heesch
1325 S. Colorado Blvd., B300
Denver, CO 80222

Linda@BIAColorado.org
(303) 562-0401
Fax (303) 355-9968

BIAColorado.org

Applicant's Name: _____Date:_____/_____/_____

Authorization to Release and Share Protected Health Information (PHI)

I hereby consent to and authorize the Brain Injury Alliance of Colorado and its employees, to obtain from, and share individually identifiable protected health information with:

Breckenridge Outdoor Education Center (BOEC)
PO Box 697
Breckenridge, CO 80424
970.453.6422

Purpose of Information Disclosure: Services through the Brain Injury Alliance of Colorado Recreation Programs.

I understand that this authorization is voluntary. I understand that if the individuals/organizations authorized by this release to receive or share my information is not a health plan or health care provider, the released information may be subject to re-disclosure and no longer protected by federal privacy regulations.

Participant Information:

Name: _____ Date of Birth:_____/_____/_____

Guardian or Power of Attorney Information, (If Applicable)

Name: _____ Phone: _____

Role (Guardian or POA): _____

Relationship: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that unless I specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose which will be 1 year from the date of release signed.

I also understand that I may revoke this authorization at any time which will be 1 year from the date of release signed and that I will be asked to sign the Revocation Section found below. I further understand that any release of information prior to the rescinded date is legal and binding.

I also understand that I may refuse to sign this authorization and that my services will not be affected if I do not sign.

I further understand that I may request a copy of this signed authorization and that I may see and copy the information described on this form if I ask for it.

Signature _____ Date: ____ /____ /____

Witness (Applicant/Guardian/POA Signature) (If Required): _____

Applicant's Name: _____Date:_____/_____/_____

Revocation Section (Unless you would like to TAKE AWAY the above privileges, please do not sign.)

I no longer authorize the above-named parties to release and share my Protected Health Information.

Signature _____ Date: ____ /____ /____

Witness (Applicant/Guardian/POA Signature) (If Required): _____

Applicant's Name: _____Date:_____/_____/_____

Section Three: Policies

Release of Liability and Waiver of Legal Rights (read carefully before signing)

WARNING, ASSUMPTION OF RISK, RELEASE OF LIABILITY AND INDEMNITY AGREEMENT AND CONSENT FOR MEDICAL TREATMENT.

BRAIN INJURY ALLIANCE OF COLORADO ("BIAC") RECREATION PROGRAMS

The Participant identified below, if at least 18 years old, or, if participant is younger than 18 or is otherwise a protected person ("Protected Person"), the Protected Person's parent or legal guardian, has read this agreement and has signed it on behalf of him/herself and the Protected Person, if applicable. The adult Participant or the Protected Person's parent or legal guardian will be referred to herein as "Adult", and Adult and the Protected Person are collectively referred to as the "Undersigned". "Participant" refers to the person actually taking part in some or all of the BIAC Recreation Programs described below (collectively "Programs", individually a "Program"). The Undersigned understand and agree that Participant will not be permitted to take part in a Program unless this Warning, Assumption of Risk, Release of Liability and Indemnity Agreement and Consent for Medical Treatment ("Agreement") is fully executed.

UNDERSIGNED UNDERSTAND AND AGREE THAT THIS AGREEMENT WILL APPLY FOR EACH AND EVERY DAY PARTICIPANT ENGAGES IN ANY PROGRAM DURING WITHOUT REQUIRING UNDERSIGNED TO SIGN AN ADDITIONAL AGREEMENT FOR EACH DAY AND/OR EACH PROGRAM UNTIL UNDERSIGNED REVOKE IT IN WRITING AND THAT WRITING IS ACCEPTED IN WRITING, SIGNED BY BIAC'S AUTHORIZED REPRESENTATIVE. ADULT ACKNOWLEDGES, UNDERSTANDS AND AGREES THAT BY SIGNING THIS AGREEMENT ADULT FOR HIM/HER SELF AND, IF APPLICABLE, ON BEHALF OF THE PROTECTED PERSON, IS ASSUMING RISKS, WAIVING RIGHTS AND RELEASING CLAIMS IN ADDITION TO THOSE ADDRESSED BY COLORADO LAW. UNDERSIGNED UNDERSTAND AND AGREE THAT ASSUMPTIONS OF RISK AND LIMITATIONS OF LIABILITY AS SET FORTH IN COLORADO LAW SHALL APPLY TO EVERY PROGRAM IN WHICH PARTICIPANT ENGAGES THROUGH OR IN CONNECTION WITH BIAC WHETHER INSIDE OR OUTSIDE OF THE STATE OF COLORADO.

Undersigned understand and agree that indoor and outdoor recreational Programs involve certain dangers and risks that can lead to injury and death. Such risks and dangers include, without limitation, dehydration, overexertion, heat related injuries, insect bites/stings, rapidly changing weather conditions, exposure to the sun, hail, rain and lightning, wildlife encounters, uneven terrain and playing fields, rocks and gravel and potentially slippery conditions and/or travel to or from an Program. For those Programs taking place in Colorado, additional risks include, but are not limited, to reduced oxygen in the air at high altitude, falling trees and limbs and increased risk of dehydration.

By signing this Agreement Adult on his/her own behalf and, if applicable, on behalf of Protected Person acknowledges the general risks described above and the specific risks associated with the Programs and, as a condition to Participant engaging in the Programs agrees to:

(1) ASSUME ANY AND ALL RISKS OF INJURY OR DEATH to the Participant while or as a result of participating in any Program; (2) WAIVE, RELEASE, and NOT SUE, MAKE ANY CLAIMS OR FILE ANY ACTIONS against BIAC, all Program sponsors, operators of events, owners and operators of training and/or Program venue and owners of professional sports teams affiliated with any Program, each of their insurance carriers, subsidiaries, affiliates, officers, directors, shareholders, members, representatives, assignees, employees, volunteers, and agents, and equipment manufacturers and distributors (hereinafter the "Indemnified Parties") that are based on or that result from, in whole or in part, participation in Programs;

INDEMNIFY, DEFEND AND HOLD THE INDEMNIFIED PARTIES HARMLESS from any and all claims, demands, actions, causes of action, losses or liabilities whatsoever arising from or related to any loss, damage or injury, including death, that may be sustained by Participant or caused to others or their property by Participant while taking part in any Program, including, but not limited, to those injuries and damages caused by negligence and/or breach of warranty, express or implied, on the part of the Indemnified Parties. Undersigned agree to pay all costs including reasonable attorneys' fees and disbursements incurred by any Indemnified Party in defending an investigation, claim or suit brought by or on behalf of Undersigned.

PROGRAMS:

RAFTING, KAYAKING, PADDLE BOARDING, CANOEING, WATER SPORTS, CAMPING, HIKING, FISHING, FIELD AND COURT SPORTS, ROCK CLIMBING, ROAD BIKING, CLIMBING WALL.

The programs involve risks, including, but not limited to, choice of boating course, carrying boats and other equipment, accidents or illness in remote places, changing weather and water conditions, lightning, hidden and underwater rocks, logs and plant life, and other obstacles, changing and unpredictable currents, drowning, hypothermia, exposure to the elements, overturning,

Release of Liability and Waiver of Legal Rights (continued)

entrapment of body parts, contact with obstacles or other persons participating in the same or similar Programs, negligence or misconduct of such persons, slipping and falling, and equipment failure.

Camping, hiking and fishing are HAZARDOUS Programs that involve risks, including, but not limited to, exposure to the and elements, lightning, hypothermia, changing weather conditions, possibility of becoming lost or disoriented, drowning, wildlife encounters, dangers caused by other persons engaged in similar Programs and the negligence of such persons, misuse or careless use of equipment, equipment failure, slippery, uneven and unstable footing, hitting rocks or other objects and the possible occurrence of landslides and flooding.

Some of the risks and dangers, involved in participation in field and court sports include without limitation, the action or inaction of the Participant or others participating in the Programs, the condition of the premises where the Programs take place, actions or inactions of coaches, trainers, supervisors, observers, and attendants conducting the Programs and risks inherent in the sports themselves such as throwing, catching and hitting balls, contact with other participants and use of any equipment provided or made available by BIAC and the potential for equipment malfunction.

The Climbing Wall is a HAZARDOUS Program that involves risks, including, but not limited to, failure of equipment and/or rope failure, misuse or careless use of equipment, improper use of equipment, loose holds, slipping and falling.

Rock Climbing including bouldering, rappelling, and Tyrolean bridge Programs, are HAZARDOUS Programs that involve risks, including, but not limited to, failure of equipment and/or rope failure, slipping and falling, exposure to changing and dangerous weather conditions, lightning, uncertain, slippery and unstable surfaces for footing and hand holds, dangers caused by other persons engaged in similar Programs, misuse or careless use of equipment, improper use of equipment, the possible occurrence of landslides and falling stones and other objects. Rock Climbing also involves strenuous physical Program that may be hazardous to some people due to their physical condition and the high altitude at which the climbing occurs.

Road biking is a HAZARDOUS Program that involves risks, including, but not limited to, uneven and/or slippery road conditions, narrow roads, variations in terrain, bumps, loose gravel and dirt, wet surfaces, holes and potholes, debris, equipment failure, including sudden flat tires, encountering vehicles, animals, pedestrians and other cyclists, negligence or reckless conduct of drivers or others and exposure to the elements including rain, wind and lightning.

The ropes course and slack line training are HAZARDOUS Programs that involve risks including but not limited to failure.

Obstacle courses are HAZARDOUS Programs which can result in serious injury or death. Obstacle courses are Programs that involve running, climbing, swinging, vaulting, jumping, rolling and other full body movements on, over, under, and off of obstacles. These Programs involve risks including but not limited to tripping, falling, rope burns, collisions or falls off of course obstacles, overexertion, and dehydration.

Undersigned recognize that injuries are a common and ordinary occurrence of participation in the Programs, and that death may even result. Nonetheless and with full knowledge and understanding of the above general and specifically identified risks involved in the various Programs, Adult voluntarily elects to, or, if applicable, chooses to allow Protected Person to participate in the Programs. Undersigned understand and agree that to reduce the risk of injury or death the Participant will wear a helmet at all times while bicycle riding, or other skating Programs, rock climbing, rafting, canoeing or kayaking. Undersigned will, to the extent possible, follow carefully all instructions on the safe and proper use of the equipment and will ask questions and request instructions so that the function and proper and safe use of all equipment rented or otherwise made available to Participant is clear to and understood by the Adult Participant or by the parent or legal guardian of the Protected Person so that such may be explained to and, to the extent reasonably possible, understood by the Protected Person before the Program is undertaken. Undersigned understand and agree that helmets cannot guarantee the wearers safety nor can protect against all potential head injuries or prevent injury to the face, neck or spinal cord.

Undersigned accept for use any equipment provided to Participant "AS IS" and accept full responsibility for its care and will pay for any loss or damage, other than reasonable wear resulting from its use.

The Undersigned understand, acknowledge and agree that he/she is responsible for determining Participant's medical, physical or other qualifications or suitability for participating in the Program. The Undersigned authorize any Indemnified Party and/or their authorized personnel to call for medical care for the Participant or to transport the Participant to a medical facility or hospital if, in the opinion of such personnel, medical attention is needed. The Undersigned understand and agree that upon arrival of medical personnel or, where applicable, Participant's transportation to any such medical facility or hospital that Indemnified Party shall have no further responsibility for Participant. Further, the Undersigned agree to pay all costs associated with such medical care and related transportation provided for Participant and shall indemnify and hold harmless the Indemnified Party

Release of Liability and Waiver of Legal Rights (continued)

for any costs incurred therein, or any claims originating therefrom. The Undersigned are advised and acknowledge that, before participating in the Program, Participant should be covered by personal health insurance sufficient to cover any expenses that may result from an injury occurring during or in connection with the Program.

In consideration for participation in an Program, Adult agrees for him/herself and on behalf of Protected Person, if applicable, that ALL claims arising from or related to any Program, including for injury to person or property and/or death shall be GOVERNED BY COLORADO LAW, without regard to conflicts of law principles, and that EXCLUSIVE JURISDICTION shall be in the Grand County, Colorado District Court or in Federal Court for the District of Colorado. UNDERSIGNED VOLUNTARILY AND IRREVOCABLY WAIVE ANY OBJECTION TO SUCH LAW AND JURISDICTION.

Undersigned give BIAC permission to take and use photographs, video and audio recordings, or movies of Participant taken during an Program for any purpose in promoting BIAC or related Programs of BIAC in print, brochures, advertisements, films or videos and on broadcast presentations of any sort.

This Agreement shall be binding to the fullest extent permitted by law. If any provision of this Agreement is found to be unenforceable, the remaining terms shall be enforceable. THE UNDERSIGNED PARENT OR LEGAL GUARDIAN REPRESENTS AND ACKNOWLEDGES THAT HE/SHE IS ENTITLED TO AND IS SIGNING THIS AGREEMENT ON BEHALF OF PROTECTED PERSON AND THAT PROTECTED PERSON WILL BE BOUND BY ALL THE TERMS OF THIS AGREEMENT. UNDERSIGNED UNDERSTAND AND AGREE THAT IF THIS AGREEMENT IS NOT SIGNED ON BEHALF OF PROTECTED PERSON, PROTECTED PERSON WILL NOT BE PERMITTED TO PARTICIPATE IN ANY PROGRAMS.

This Agreement shall be binding upon Undersigned's' assignees, subrogors, distributors, heirs, next of kin, executors and personal representatives.

Applicant's Name: _____Date:_____/_____/_____

Privacy Practices

The Brain Injury Alliance of Colorado (BIAC) is required to follow the privacy practices described in this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time and apply any changes to all medical information we have. If we do so, we will post a new Notice on our website at http://biacolorado.org/privacy. You may request a copy of the new Notice by contacting us at 303.355.9969 or 888.331.3311.

YOUR RIGHTS TO PRIVACY: Your medical information will not be shared and/or disclosed without your permission except as described in this Notice under Disclosures Not Requiring Your Permission and may withdraw this authorization in writing at any time. You have the right to ask the Brain Injury Alliance of Colorado to:

- Contact you by telephone, fax, mail, or e-mail at a specific number or address;
- Limit the use and/or disclosure of your medical information (we are not required by law to agree to your request);
- Look at or have a copy of any part of your designated record set maintained by the Brain Injury Alliance of Colorado (you may be charged processing and/or postal fees for this request);
- Change or add information to your designated record set (original documents may not be changed);
- Provide a list of disclosures of your medical information made after April 14, 2003 (which will not include disclosures for purposed of treatment/treatment alternatives, payment, health care operations, appointments, or those made to you or with your permission)

You may access your medical information by submitting a request to BIAC at 1325 S. Colorado Blvd. B300, Denver, CO 80222

DISCLOSURES NOT REQUIRING YOUR PERMISSION: The Brain Injury Alliance of Colorado can make disclosures under the following circumstances without your permission, under court order or law. Whenever permitted, your will be informed of these disclosures:

- Government Agencies and/or organizations Providing Benefits, Services, or Disaster Relief – For example, we may disclose information to the Red Cross for you to receive benefits during a natural disaster.
- Public Health – For example, we may disclose medical information for disease control and prevention, problems with medical products or medications, or prevent abuse, neglect or domestic violence.
- Health Oversight Activities – For example, we may disclose information to approved government agencies such as those responsible for the Medicaid program, U.S. Department of Health and Human Services or the Office of Civil Rights.
- Judicial and Administrative Hearings –For example, we may disclose specific medical information under court order or C.R.S. 27-10.
- Law Enforcement Purposes – For example, we may disclose information for law enforcement purposes, such as subpoenas.
- Coroners, Medical Examiners, and Funeral Directors - For example, we may disclose information to such professionals who need it to administer their work.
- Organ Donation and Disease Registries - For example, we may disclose medical information to authorized cancer or transplant registries.
- Research Purposes- For example, we may disclose information to assist with medical or psychiatric research.
- To Avert Serious Threat to Health, Safety, or Emergency Situation - For example, we may disclose information to prevent a serious threat to the health and safety or an individual or the public.
- Specialized Government Functions - For example, we may disclose information for national security purposes or to military authorities if you have been a member of the armed forces.
- Correctional Institutions - We may disclose medical information to correctional facilities to maintain the health, safety, and security of this system.
- Workers' Compensation - We may disclose medical information to programs that provide benefits for work related injuries without regard to fault.
- As Otherwise Required By Law

Applicant's Name: _____Date:_____/_____/_____

Additional Policies

Early Departure: If, for any reason, it becomes necessary for participant to leave the program before the scheduled finish, caregiver(s)/parent(s) are required to make arrangements for the participant to leave the program as soon as possible.

Position in the Program: The participant spot is not confirmed until all the paperwork and payment(s) have been received. If the final payment is not received within 2 weeks of the program, the participant's spot may be given to someone on the waitlist.

Cancellation: No refunds will be given for cancellations, unless deemed necessary.

UNDERSIGNED HAVE CAREFULLY READ THIS AGREEMENT, UNDERSTAND ITS CONTENTS AND SIGN IT WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE.

Executed this _____ day of _____, _____.

Applicant's Signature _____ Date: ____ /____ /____

PRINT Name of Participant: _____ Participant Date of Birth: ____ /____ /____

Parent or Legal Guardian's Signature _____ Date: ____ /____ /____
(if applicable)

PRINT Name of Parent or Legal Guardian: _____
(if applicable)