ADMISSION
Wilderness Treatment Center is an inpatient free-standing facility for males 14-24 years old. The program is approximately 60 days with the actual length of stay based on how the patient progresses through the treatment process. Patients stay is typically 60-67 days. Patients may be admitted either by self, by their physicians, family, clergy, or other treatment programs and professionals.

Admissions are scheduled seven days a week. Contact an admissions coordinator at the business office Monday through Sunday from 8:00 a.m. to 5:00 p.m. M.S.T. to make necessary arrangements.

COST
$525 Per Day – all room, board, therapy, training sessions, equine therapy, wilderness trip, ropes course, family week, transportation to AA meetings, doctor visits, physicals, family consultations, psychologist reviews, nurse visits, 2.5 Academic credits and airport pickup and departure.

$0 Clothing Allowance – Clothing for Wilderness Expedition, fishing license, film, etc. All equipment such as backpacks, sleeping bags, etc. is provided. Any equipment damage due to abuse will be billed to patient’s account.

$0 Family Week – Our 4 ½ day family program is held once per month, utilizing the principles of the Al-Anon program and family system dynamics. Our family therapists are available Sunday through Thursday for phone conferences and will arrange a family week attendance with you.

$0 Aftercare – Aftercare is the responsibility of the patient and family. The patient and his counselor will make arrangements for aftercare during the last phase of treatment based on recommendations by the treatment team.

ACCREDITATION
Wilderness Treatment Center is a licensed, free-standing, in-patient and day treatment program that uses the steps of A.A. and N.A. The program is medically supervised and covered by some medical insurance plans.

Wilderness Treatment Center is licensed through the State of Montana Department of Public Health and Human Services, Addiction and Mental Health Disorders Division.
FEE PAYMENT AGREEMENT

***** PLEASE SIGN AND FAX BACK *****

Date:_______________ Patient Name:____________________________________

I understand that the cost of treatment is $525 per day for Wilderness Treatment Center’s 60 day program. If the patient stays for 60 days, the cost is $31,500. If the patient stays longer than 60 days, the charge is still $525 for each additional day. Check, wire or cash are acceptable forms of payment. We also accept Visa, MasterCard, Discover and American Express and will include a non-refundable 3% administrative fee on each transaction if a card is used for payment. Checks, cash or wires are not subject to administrative fees.

- The amount of the down payment is $10,500 and is due upon admission.
- The 30 day payment will be $10,500 and is due 30 days after admission.
- The final payment is $10,500 plus any additional days and is due upon discharge.

Any additional balance for days beyond the 60 day stay is due and payable upon discharge from our program. Most patients stay is between 60-67 days. 60 days is the minimum amount of programming days to graduate our program. A final bill will be sent after discharge for any additional charges beyond the discharge date.

The costs cover: all room, board, therapy, training sessions, equine therapy, wilderness trip, wilderness equipment, ropes course, family week, transportation to AA meetings, doctor visit/physical, family consultations, psychologist review, nurse visits, 2.5 Academic credits and airport pickup and departure if necessary.

Past due payments shall bear interest at the rate of 18%. This includes the down payment, 30 day payment, and final payment. All accounts not paid within 60 days of discharge shall be subject to collection in accordance with our collection policy and that in the event of collection, I agree to pay any and all costs of collection, including litigation costs and reasonable attorney fees incurred.

Wilderness Treatment Center will try and work with your insurance carrier, however, please note that there is no guarantee of payment from the carrier. An insurance claim will be submitted after discharge for WTC. If payment from the insurance carrier comes directly to WTC, a refund for any overpayment will be processed in a timely manner.

Signature                                          Signature

SS#_____________________________________________ SS#_____________________________________________

Address and Phone
ACKNOWLEDGEMENT OF RISK
ASSUMPTION OF RISK AND RESPONSIBILITY

PLEASE READ CAREFULLY

All participants will be actively involved in a wilderness expedition during week five, six, and seven. There are significant elements of risk in any adventure that travels beyond the trailhead in which trekking, hiking, mountaineering, rappelling, rock climbing, skiing, solo, snowshoes, backpacking, fishing or initiative games can occur.

ACKNOWLEDGEMENT OF RISK:

In agreeing to have your son attend WTC, you recognize the fact that there is an inherent danger in the following activities: 1) Falls, 2) Cold weather related injuries including hypothermia and frostbite, 3) Heat-related illness including heat exhaustion and heat stroke, 4) Acts of nature which may include: avalanche, rock falls, crevice falls, high winds and severe cold, 5) River crossings, fording or travel, including travel to and from the activities, 6) Risks associated with crossing, climbing or down climbing rocks and ice, 7) Equipment failure. I/we also acknowledge that certain foreseeable or unforeseeable events may contribute to the unpredictability of the activity. Personal property may be damaged or lost and that I/we may suffer an accident or illness in remote places where there is no available medical facility and that wearing a helmet and appropriate clothing are basic safety precautions. As a potential user of the services Wilderness Treatment Center provides you have a right to ask the safety record and accident incidents of past participants at Wilderness Treatment Center.

PARENT SIGNATURE ____________________________ PATIENT SIGNATURE ____________________________
CONSENT TO MEDICAL CARE AND TREATMENT

I, ____________________________________________ (legal guardian), authorize all medical and surgical treatment, x-ray, laboratory, anesthesia, and other medical/hospital procedures as may be performed or prescribed by a licensed physician for, ____________________________________________(patient’s name) and waive my right to informed consent of treatment.

Birth Date ____________________________________________
Birthplace ____________________________________________
Mother’s Maiden Name __________________________________
Allergies _____________________________________________
Chronic Illnesses _______________________________________
Regular Medications ___________________________________
Date of Last Tetanus Immunization _________________________
Patient’s Physician _____________________________________
Physician’s Phone Number _______________________________
Mother’s Emergency Contact Number ______________________
Father’s Emergency Contact Number ______________________

_________________________________  ______________________________
Date        Signature of Legal Guardian

_________________________________  ______________________________
Witness       Patient’s Address
HEALTH INSURANCE AUTHORIZATION FORM

WILDERNESS TREATMENT CENTER

(Patient)

In cases where the patient is covered for the cost of care and treatment, under an insurance plan, either his own or under that of the responsible person: it is necessary to obtain the signature of the policy-holder on the following authorizations before a claim may be submitted for payment.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above treatment center to release medical information necessary to process this claim following the HIPPA Act.

Date:_____________________ Signature:____________________________________

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment of the Hospital Benefits herein specified and otherwise payable to me, directly to the Treatment Center. I also understand that I am financially responsible for all charges not covered by the insurance company.

Date:_____________________ Signature:____________________________________

Please answer the following questions to the best of your ability.

Insurance Company’s Name and Address:________________________________________________

______________________________________________________________________________

Insured’s Name and Address:______________________________________________________

______________________________________________________________________________

Insured’s Identifying Number/Social Security Number:________________________________

Insured’s Group Number:____________________ Policy Number:________________________

Insured’s Certificate Number or Other:_______________________________________________

If patient has other health insurance, health plan or state assistance, enter its name, address, and policy or medical assistance number here:______________________________________________

______________________________________________________________________________
Wilderness Treatment Center

Patient#__________________      Date: _______________

SSN:_____________________

Patient Name:__________________ Age:____ DOB:_____________

How did you hear about us:________________________________________________________

Parent_________________________________________________________________________

Phone_________________________________________________________________________

Address_______________________________________________________________________

Insurance__________________________________ Policy #_____________________________

Group #____________________________ Phone______________________________________

Employment_______________________________ SSN:________________________________

Parent_________________________________________________________________________

Phone_________________________________________________________________________

Address_______________________________________________________________________

Drug of Choice____________________________ Secondary____________________________

Duration and Frequency of Use_____________________________________________________

Prior Treatment: Yes_________ No_________ Inpatient_________ Outpatient_________

Previous Programs and Dates:

1)______________________________________________________________

2)______________________________________________________________

3)______________________________________________________________

4)______________________________________________________________

5)______________________________________________________________

6)______________________________________________________________
Current Living Situation:__________________________________________________________

Siblings (Name and Ages)__________________________________________________________

Physical Condition_______________________________________________________________

Allergies_______________________________________________________________________

Medications_____________________________________________________________________

Family Physician_________________________________Phone__________________________

Immunization Record_____________________________________________________________

Person’s perception of own alcohol/drug problem: Accepts___________ Denies___________

Comments_______________________________________________________________________

Age person started using chemicals________________________________________________

Consequences of use________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Legal Status:  N/A_____ Probation_____ Parole_____ Court Ordered_____ 

Probation Officer____________________________________________ Phone________________

Attorney___________________________________________Phone_______________________

Mental Status (any mental health concerns/history of trauma/etc…) 

______________________________________________________________________________

______________________________________________________________________________

Needs or Focus Ares_____________________________________________________________

______________________________________________________________________________

Additional Information___________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
The following is an explanation of the billing procedures for WTC. The cost of treatment is $525 per day and the average length of stay is 60 days, however, there are many factors that are involved in the length of stay. The progress of the patient, admission date, the family week schedule and the wilderness trip so approximately 67 days is a possibility.

The $525 per day includes:

- Room and Board
- Individual and Group Therapy
- Education groups, lectures and videos
- Parent consultation and weekly updates
- Complete physical exam and lab work
- Psychological test
- Family week
- Equine Therapy
- High ropes course
- Wilderness equipment and trip supplies
- Recommendations with the aftercare placement

The extra charges that may be on the bill are any extra doctor visits for sickness, medication reviews, or insurance phone conferences with the Medical Director and the insurance company. Any medications, extra blood tests, x-rays, damages or incidental expenses will be on the final bill.

If there is insurance being utilized for treatment we need to know prior to admission as it will affect any coverage if we send it in late due to preauthorization. The insurance company is not billed until the patient is discharged for treatment and it then takes a minimum of 30 days to hear anything. The down payment, 30 day and final payment must be paid timely on each of the due dates. Past due payments shall bear interest at the rate of 18%.

We have a 72 hour hold policy which means there is no fee adjustment or reductions for periods in which a patient is not physically at WTC, if they leave the facility unauthorized we hold the bed and bill accordingly. This policy is leveraged only if we have a waiting list for treatment.

Please read this and sign and return with the fee payment agreement that you understand the billing procedure and agree with the treatment process, length of stay and agree to pay accordingly.

Date: ___________________ Parent’s Name: __________________________________________

Patient Name: ________________________________________________________________
Packing List

REQUIRED
- Jeans
- Long sleeved shirts
- T-Shirts
- Coat, Hat, Gloves
- Tennis Shoes
- Socks (for winter heavy socks)
- Underwear (long underwear in winter months)
- Toiletries (toothpaste, toothbrush, shampoo, razors, etc.)
- Shorts in summer months
- Flip-Flops for shower
- Writing paper, enveloped, stamps
- Chap Stick
- Personal account money ($100 recommended)

OPTIONAL
- Sweatshirt
- Lightweight hiking boots
- Rain Jacket

Because our facility is located on a working cattle ranch, dress is very casual. Please bring clothes that you don’t mind getting dirty, and if possible, mark them with your name. Laundry will be done every four days, so bring enough clothes for that kind of time period, but not much more, as storage is limited. We provide bedding and towels.

DO NOT bring any electronics, essential oils or jewelry. (You will not be allowed to wear jewelry on the wilderness trip and all cell phones will be locked up on admission) Also, DO NOT bring magazines or books (besides treatment material, AA literature or religious bibles). Chewing gum is not allowed. Please notify us before admission if the patient is on prescribed medication.

Wilderness Treatment Center is not responsible for personal property brought for the patient’s own use. It is the patient's responsibility to take care of the personal property and to turn in any valuables in their possession. We are not responsible for any belongings left (patients leaving belongings at time of discharge or if a patient leaves the facility against staff advice) or for mailing any articles left at our facility.
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