

HEALING TRAUMA PROGRAM WELCOME LETTER

Welcome to Onsite! We're glad you plan to join us. Our primary goal for the week is to create as safe a place as possible for you to do your work. To work towards this, we do our best to let you know what to expect. We want to be as clear as possible about our policies, the facility, and the schedule, so you can be more comfortable while you're here.

We will need to have the enclosed participant information materials returned to us no later than **7 days after date of registration (if registering within 2 weeks of program start date, information is due 3 days after date of registration)**. **Failure to return your paperwork by the required date will jeopardize your participation in this program.**

GUIDELINES:

Please read the enclosed guidelines. They have been compiled to promote safety and consistency in the community. You will be asked to sign and return a statement indicating that you have read, understand, and agree to follow these guidelines.

SCHEDULE:

The program days are Friday through Friday. We begin with registration Friday afternoon. Please plan to arrive at the Nashville Airport no later than 3:00 p.m. You will need to arrive at the Onsite campus after 2:30 p.m. and before 4:30 p.m. on Friday, if you are driving. If you wish to come a day early or stay a day late, see enclosed suggested hotel list.

TRAVEL:

Please do not make travel arrangements until you have received verbal notification that you have been accepted into the program. You will receive notification of approval after your participant forms have been returned to our office and reviewed by our clinical supervisor.

AIR: **Arrival:** Please note that your air travel destination is Nashville, Tennessee (BNA). Each participant will be responsible for making his/her own air travel arrangements. Onsite provides shuttle service at 12:30 p.m. and 3:30 p.m. from the airport to our facility on your program starting date. When scheduling your flights, please arrive at the airport by 3:00 p.m.

Departure: Onsite provides return shuttle service to the Nashville airport at 7:00 am on the final morning of your program. Do not schedule your departing flight before 10:00 a.m. on the last day of the program.

CAR: If you are driving, consult the enclosed map. Please plan to arrive after 2:30 p.m. and before 4:30 p.m.

See the enclosed travel pages for specific travel information.

ACCOMMODATIONS:

The Onsite program you have registered for will be held at the Drouillard House and Conference Center, a 130-year-old historically renovated mansion on 70 acres in the beautiful Middle Tennessee countryside. The program site is approximately 40 miles northwest of Nashville. All participants will stay at the program site.

Your accommodations are similar to a hotel with a few exceptions:

--The rooms contain two or three beds and you will stay with one or two roommates. Men and women will room separately.

--It is important that you understand that Onsite cannot anticipate, monitor, or control participants unique sleeping/living habits or their sensitivities to others habits. If you have any unique sensitivities such as allergies to hair spray, perfume, etc., snoring or other night sounds, light, etc., it is your responsibility to take care of those sensitivities by bringing to the program items needed to provide for your comfort and safety. Such items might include allergy masks, sleeping masks, ear plugs, headphones, white noise machines, etc.

--Onsite is not in a position to offer any relief from such sensitivities by roommate changes, room changes, etc. If you have any such unique sensitivities or sleeping conditions such as the use of a breathing machine, insomnia, excessive snoring, etc., let us know so we can determine our ability to accommodate your special needs. We **may** have a limited number of private rooms available at an additional cost; call Onsite for details.

--There are no televisions or telephones in the rooms, so that you can focus on the work you are here to do. There will be a phone available for emergency use. Please let necessary people at home know that they can get in touch with you in an emergency by calling (800) 341-7432 weekdays 8:00 am – 5:00 pm, and (615) 417-4733 after 5:00 pm and weekends. Have them indicate they are leaving an emergency message for an **Onsite** participant.

--The following are provided:

- Towels
- Soap and bed linens
- Dining room services
- Snacks of fresh fruit and beverages
- Alarm clock (wake up service is not provided)

MEALS:

Your total program cost includes all meals from dinner following your arrival at the program site through breakfast on the final morning, snacks, and beverages. All meals are well balanced, nutritious, varied and tasty. Meals are served buffet style. Our meals are designed with enough alternatives to accommodate most food requirements. **Sorry, we will be unable to accommodate special requests. Food is not permitted in rooms nor is food to be brought to the program. Please call our office if you have questions concerning food.** Since we will be serving items that contain little or no caffeine, we suggest that you gradually reduce your caffeine intake before you arrive. Regular coffee will be offered between 6:30 a.m. – 8:00 a.m.

WHAT TO BRING:

A checklist is provided for your packing convenience. We are located 10 miles from any stores and unable to provide necessary toiletries. Dress is very casual.

General

- Heavy jacket for fall/winter months
- Shorts (no short shorts please)
- Sweatshirts/sweaters
- Closed toed shoes (i.e., tennis shoes)
- All daily toiletries (i.e., toothbrush, deodorant, etc.)
- Leave Onsite emergency phone number (615) 417-4733 with _____
- Light jacket for spring/summer months
- Blue jeans/casual pants
- Shirts/blouses (at least one long sleeved)
- 1 pair casual shoes
- Broad brimmed hat
- Sunscreen
- Insect repellent

Optional

- Notebooks/pens
- Postcards
- Camera
- Stamps

Please do not bring

- Expensive jewelry or valuables
- Spandex or tight fitting outer-wear
- Clothing promoting alcohol, drugs, sex, etc
- Music players, radios, computers (including IPads), computer equipment (i.e. blackberries, anything with a screen, etc.), video cameras
- Exercise equipment (i.e. weights, roller blades, jump ropes, etc.)
- Short shorts, including running shorts
- Halter tops or low cut tank tops
- Tops that exposes the midriff, or low riding pants
- Musical instruments

PAYMENT:

This is a prepaid program. The full program cost must be paid at time of registration of the program before you will be admitted. We accept MasterCard, Visa and Discover. Your program fee covers double or triple occupancy lodging, program fees, on-campus meals and all activities.

Program Cost \$ 4600.00

Due at Registration \$ _____

The amount due may not include transfer fee or single rooms.

CANCELLATIONS

For all programs, except Individual, Couples, and Family Intensives and Montana Equine, if a cancellation occurs 14 or more days prior to a program's start date, the full amount, less \$500 processing fee per person, will be refunded. For Individual, Couples, and Family Intensives and Montana Equine, half of the program fee is non-refundable. If a cancellation occurs less than 14 days before the program's start date, the entire amount will be non-refundable. No refunds are given for any program if a participant does not attend, leaves the program early, or completes the program.

TRANSFERS

For all programs, except Individual, Couples, and Family Intensives and Montana Equine, participants must submit a request to be transferred in writing 14 days prior to the program start date. Transferring to another program will incur a \$100 per person processing fee. Participants will not be permitted to transfer unless the request has been received and approved. For Individual, Couples, and Family Intensives and Montana Equine, no transfers will be permitted.

If you have any questions, please feel free to let us know. We look forward to having you join us in Cumberland Furnace!

Sincerely,

Lizzy Curtis
Program Director

HEALING TRAUMA PROGRAM GUIDELINES

These guidelines have been created over the last 30 years to help ensure safety and consistency in the community during your stay here. Past participants, who have been concerned about the thoroughness of the guidelines when first received, have appreciated their value during their experience at the program. Please read them carefully.

CHEMICALS DURING PROGRAM AND MEDICAL NEEDS

Mood altering chemicals, including alcohol, are not allowed. You cannot arrive at the program with the appearance of alcohol/intoxication; if we perceive that you are intoxicated you will forfeit your program fees, you will be asked to leave and you would forfeit your right to participate in the program. All nicotine use in any form is prohibited in this program. Those participants who will be withdrawing from nicotine use will be given special instructions at the opening of the program.

All prescription drugs are to be cleared in advanced by the clinical supervisor who may need to consult with your attending physician. In the event this becomes necessary, you will be required to sign a medical release form to enable our staff to work directly with your physician. If you have severe allergies of any kind please come with the necessary approved medication in the unlikely event of any reaction(s). Also any change in dosage or medication needs to be reported to the supervisor on the first evening of the program. If you bring non-prescription medications to the program that we feel will interfere with your work or your ability to get the most out of this experience, you may be asked to allow us to hold this medication for the duration of the program. If you have any questions prior to the program regarding any prescription or non-prescription drugs you need to take, please check with Onsite's clinical supervisor. During the program, please check with the program supervisor.

CONFIDENTIALITY

Confidentiality regulations protect your right to anonymity as a participant in this program. We expect that you will protect that right for fellow participants: what you choose to say to others about yourself and/or your experience is up to you. Be aware that because Onsite is a group process, we cannot guarantee that group participants will keep confidentiality.

All licensed counselors and helping professionals who function as our group leaders are required to report certain information where there is a clear and immediate danger to you or someone you could endanger, or indication of abuse to a minor and/or confirmed or suspected domestic violence/abuse. (See the page titled INFORMATION CONCERNING YOUR HEALTH RECORDS for more information.) Please ask permission of participants before you use your camera. Do not post photos on social networking sites without written permission from all participants in photos. Cameras are not allowed during group process or presentations. Camcorders are prohibited at any time.

WE ASK THAT YOU DO NOT SHARE YOUR PROFESSION OR OCCUPATION WITH OTHER PARTICIPANTS BEFORE OR DURING THE PROGRAM.

ROOMING

This is an intense program. In order to provide safety, privacy, and a sanctuary, assigned sleeping rooms will be off limits to all other participants at all times.

--It is important that you understand that Onsite cannot anticipate, monitor, or control participants unique sleeping/living habits or their sensitivities to others habits. If you have any unique sensitivities such as allergies to hair spray, perfume, etc., snoring or other night sounds, light, etc., it is your responsibility to take care of those sensitivities by bringing to the program items needed to provide for your comfort and safety. Such items might include allergy masks, sleeping masks, ear plugs, headphones, white noise machines, etc.

--Onsite is **not** in a position to offer any relief from such sensitivities by making roommate/room changes, etc. If you have any such unique sensitivities or sleeping conditions such as the use of a breathing machine, insomnia, excessive snoring, etc. let us know so we can determine our ability to accommodate your special needs. We **may** have a limited number of private rooms available at an additional cost.

--Towels will be provided once during the week and bed linens will be provided for the week. Please respect your roommates by keeping your living area neat and your bed made. Check out time on the last day of the program will be announced. You will be asked to have your bags packed and taken to the central luggage pick up point before you arrive for breakfast. Please return room keys as directed.

Smoking, burning candles, burning incense, smudging, etc., is not permitted. Gas fireplaces may be used when you are in the room. Fireplaces are not to be left on all night or unattended.

GENERAL GUIDELINES

We require that you walk, jog, or gather in groups of three or more. We discourage pairing. On the other hand, isolation can diminish your experience here also. If you become aware of a relationship between clients that has developed, or if you currently have a relationship with other clients at this program, report that information to Onsite staff as soon as you become aware of it. Respect property. Any willful damage of property will be the financial responsibility of the participant. Use of private vehicles for any purpose is not permitted. Do not self-medicate, share medications (prescription or non-prescription), or provide health assistance to other participants, unless directed to do so by staff.

PHONES AND EMERGENCIES

At the opening of the program, you will be required to turn in your cell phones and other electronic media devices (i.e. laptops, iPads, etc.). Outgoing calls will be limited to emergency and travel calls only. Those phone arrangements will be arranged through your group leader. To help you focus on the work at hand no TV's, newspapers, or radios will be available. The phones at the

program site are for emergency use only. Please be advised that Onsite cannot provide direct medical assistance. If you need to see a doctor, the on-call staff member will be able to help you access medical assistance. Cost of transportation to and from medical assistance is not included in regular program fees.

Incoming emergency messages will be forwarded to you as soon as possible. Non-emergency incoming phone calls will be forwarded to you in a timely fashion. Except for emergencies, you will not be permitted to use the phone once the program has begun in order to help you focus on your work. Phones will be available for your use on the last day of the program to confirm or make travel arrangements.

CONTAGIOUS/INFECTIOUS CONDITIONS

We believe it is both safe and appropriate that individuals with certain medical and physical conditions be permitted to participate in our programs. Such contagious/infectious conditions may include, but are not limited to: known and unknown cold and flu viruses, hepatitis, HIV, bacterial infections, etc.

All participants and staff should exercise reasonable caution in their interactions with each other to minimize their exposure and the exposure of others to infectious diseases. We strongly suggest that individuals avoid sharing personal grooming items, such as razors, toothbrushes, etc., and that each person assume responsibility for throwing away their own tissues and other similar items they may use.

GENERAL DRESS CODE

Appropriate dress for Onsite includes comfortable, casual wear. Wear shoes outside at all times. T-shirts, sweats and jeans are all appropriate. For group, we suggest you be very comfortable. Appropriate length shorts are permitted. Inappropriate are clothing items such as: short shorts, mini skirts, halter tops, low cut tank tops, open shirts, tights, excessive jewelry.

For health reasons, you will need to wear foot coverings in the large meeting room and group rooms.

EXERCISE AND DESIGNATED AREAS

Because it is important in a program that we establish a community setting, **it is REQUIRED that participants stay on the premises at ALL TIMES.** Participants are not permitted to go into the village of Cumberland Furnace for any reason at any time during the program. Property boundaries are marked by fences and the river. In case of an emergency, contact a staff member. Use of private vehicles is not permitted during the program.

Physical activities are optional, so please be gentle with yourselves. If you are experiencing any discomfort or ailment, please notify the staff as soon as possible.

For walking, we suggest you go in small groups of three or more, and please never be alone. Also, be aware that there are snakes, ticks, fleas and other wildlife/insects in Tennessee.

DINING AND MEETING ROOMS

Please wear your nametag all week.

Participants may be asked to assist with certain tasks, such as helping set up for presentations to help facilitate the program.

We will be providing snacks and refreshments for your breaks. Snacks are to be consumed only in the areas outlined during the first orientation session. **They are not to be taken to group rooms or sleeping areas.** All participants must be a part of every meal whether or not they choose to eat, and you **must be on time for meals.** Staff may go first or cut in line so that they can get to staff meetings on time.

The philosophy of our menu is to provide meals and snacks that are nutritious and well balanced. **Sorry, we cannot accommodate special diets.** If you have special dietary needs, consult with our office before you sign up to see if our meal plan will work for you.

REMINDERS

We may take pictures throughout the week. There will be release forms to sign if you agree to have your picture used by Onsite. Please ask permission before taking pictures of participants. No photos or taping will be allowed during presentations or small group.

Complete the evaluation forms in your packet. We will collect them at the end of the week.

Please report any damage to a staff member. Onsite and the Drouillard House are not responsible for lost or stolen property. We suggest you lock your doors. Any mail that you receive will be delivered to you. Please have mail sent **c/o Onsite, 1044 Old Hwy 48 North, P.O. Box 250, Cumberland Furnace, TN 37051.** Outgoing stamped mail may be given to a staff member for mailing.

WE EXPECT THAT YOU WILL

Be honest about matters that relate to you, and be an active participant in your process, including education and group sessions.

Be considerate and respectful of the rights of fellow participants, Onsite staff and other's property. Help keep your room and community rooms clean. Attend all scheduled meetings, sessions, meals and events, and be on time. All sessions will start on time; participants are expected to be on time. If you are late, you may not be allowed in. Complete all reading, writing and other assignments. If you have concerns for your safety or well being, tell a staff member.

SUMMARY

This program can be a safe place to feel, share, and be vulnerable. In order to preserve and enhance safety, we will not hesitate to discharge someone, if necessary, for the welfare of the whole group. Grounds for discharge will include:

- a. Possession, sale or use of drugs and/or alcohol.
- b. Violating program guidelines.
- c. Actual or threatened verbal and/or physical assault.
- d. Inappropriate behavior interfering with another's experience.
- e. Dishonesty.
- f. Refusal to participate in program.

DEAR NICOTINE USER,

I applaud your courage to attend Onsite knowing our programs are nicotine free. The Onsite staff is nicotine free, and many of our group leaders and staff members are in recovery from this powerful drug. We are here to offer our experience, strength and hope during your program. We are aware that some participants attending this program are making the decision to remain abstinent only during the duration of their program, while others will be working toward full recovery from nicotine. Whichever side of the equation you find yourself on, we will support you. There will be support available to address the feelings that may be present as you withdraw both physically and emotionally from nicotine.

If you are currently using nicotine and have not begun to reduce the amount I encourage you to start now. This will help with the physical withdrawal that naturally occurs when abstaining. Reduce the amount each day so that, at the very least, your “first nicotine free day” will be the day you arrive at Onsite.

Please do not bring nicotine products to the program with you such as cigarettes, matches, lighters, chewing tobacco, cigars etc. Upon arrival we ask you to use no nicotine products for the duration of the program.

If you are using 1-2 packs of cigarettes per day, a can of chewing tobacco every two days, pipe or cigar smoking on a daily basis or more please consider using an over the counter product to help go through this first phase of withdrawal. **You may bring over-the-counter nicotine aids with you to the program such as nicorette or patches to help with withdrawal. We do not carry any over-the-counter aids.**

Other helpful tools that work to help with withdrawal symptoms include drinking extra water, exercising, breathing deeply when cravings hit, and talking with others about your commitment and feelings. Please keep in mind that cravings usually last about 2 minutes and hit every 20 minutes depending on your level of use.

I want to assure you that addressing your nicotine withdrawal will in no way block your participation or ability to get all you want from your program - in fact just the opposite is usually true. We have several group leaders that request to have individuals who are abstaining from nicotine in their small group because these participants are more present to their feelings now that a powerful suppressant is being terminated.

Once again I want to offer my congratulations and support as you start this process. Please feel free to call if you have questions and concerns.

Sincerely,

Bill Lokey
Clinical Director

INSTRUCTIONS FOR COMPLETING AND RETURNING YOUR PAPERWORK TO ONSITE:

Do not attempt to email your paperwork back to Onsite. We do not want you to risk transmission of your personal information via the internet. It will be necessary to print the forms and return them upon completion via fax or mail.

It is best to either fax your paperwork to us at (615) 789-5696, Priority Mail or Federal Express the materials to our office. If you fax the paperwork, please do not use blue ink to complete the forms. If for any reason your faxed copies are difficult to read, you will be contacted by our office and requested to bring your originals to the program with you.

For overnight mailing, send paperwork to:

Onsite
1044 Old Highway 48 North
Cumberland Furnace, TN 37051

For regular U.S. Postal Service Delivery, send paperwork to:

Onsite
P.O. Box 250
Cumberland Furnace, TN 37051

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HEALING TRAUMA PROGRAM CHECKLIST

Please review this checklist when returning your program materials:

- | | | |
|----|--|-------|
| 1. | Intake Assessment Questionnaire | _____ |
| 2. | Medical History Form | _____ |
| 3. | Program Contract with Signature | _____ |
| 4. | Health Records Information Form with Signature | _____ |
| 5. | Program Payment Information | _____ |

Thank you for your prompt completion and return of these materials. We look forward to seeing you soon. If you have any questions, please call us at (800) 341-7432.

HEALING TRAUMA PROGRAM ASSESSMENT

PLEASE COMPLETE AND RETURN TO: Onsite Workshops, P.O. Box 250, 1044 Old Hwy. 48 North, Cumberland, Furnace, TN 37051, Fax: (615) 789-5696

Date of Program: _____

Name _____ Date of Birth _____ Age _____ Female ___ Male ___

Address _____ City, State, Zip _____

Best Contact Phone Number _____ Email _____

How would you like your nametag to read? _____ Vegetarian? _____

Food Allergies? (please explain) _____

Please give a **name** and **phone number** of a person we could reach in case of an emergency while you are attending your program: _____

REFERRAL SOURCE

Identify: Therapist _____ Former Participant _____
Treatment Center _____ Conference/Workshop _____
Book _____ Mailing _____ Internet _____ Magazine _____
Other _____

Have you or a relative been to an Onsite program before? Yes ___ No ___

Name _____ Program(s) _____ Date(s) _____

Do you know anyone attending the Healing Trauma Program for which you have applied? Yes ___ No ___

If yes, Name _____

PROFESSIONAL SUPPORT

1) If under the care of a **Therapist**, please list contact information below:

Name _____ Address City, State, Zip _____

Phone _____ Fax _____ Email _____

2) If under the care of a **Psychiatrist**, please list contact information below:

Name _____ Address City, State, Zip _____

Phone _____ Fax _____ Email _____

3) If under the care of an **Interventionist, Life Coach, or Other Professional**, please list contact info below:

Name _____ Address City, State, Zip _____

Phone _____ Fax _____ Email _____

I hereby authorize the person(s) named in #1, #2, and #3 above to exchange information about me including my therapy and medical history. I also authorize Onsite representatives to send a copy of my aftercare plan to the same person(s) above and to exchange any information about my work during the Onsite program. The purpose of this information is to assist Onsite in my participation and experience in Onsite's Healing Trauma Program. (Requesting information is a routine part of our admissions procedure). I understand I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. The information provided to Onsite will be held strictly confidential and will not be released without my expressed written consent as required by law.

Participant's Signature Date _____

Initials: _____

Are you currently using any prescribed medication? Yes _____ No _____ If yes, list name, purpose, and amount:

Are you currently attending any 12-step programs? Yes _____ No _____

Program _____ Frequency? _____
Program _____ Frequency? _____
Program _____ Frequency? _____

Other than those you have already noted, are you aware of additional sources of support and help available to you locally after you complete this program? (Counselors, 12-step programs, support groups, etc)

Yes _____ No _____ If yes, list source(s):

PRESENTING ISSUES

List your goal(s) and issue(s) for attending this program:

1. _____
2. _____
3. _____

EDUCATION

Currently enrolled in school? Yes _____ No _____ Highest Academic Level Completed: _____ Major: _____
Vocational Training: Yes _____ No _____ If yes, what skill? _____

OCCUPATION

Are you currently employed? Yes _____ No _____ Full-time _____ Part-time _____ Homemaker _____ Retired _____
Where? _____ Position _____ How long at present job? _____

If married or in a committed relationship, is your partner currently employed? Yes _____ No _____
Where? _____ Position _____ How long at present job? _____

RELIGION/SPIRITUALITY

In what religion were you primarily raised? _____

How active were you in that religion? _____

What is your religion now? _____ How active are you? _____

How would you describe your current relationship with your religion/spirituality?
Good _____ Fair _____ Poor _____ Non-Existent _____

What are your present spiritual problems or needs? _____

MILITARY

Have you served in the military? Yes _____ No _____ When _____ Where? _____

Job assigned _____ Branch _____ Rank _____

LEGAL

Have you had any legal problems in any of these areas in the past two years?

Driving offenses _____ Family _____ Fights _____ Financial _____ Other _____

Describe: _____

In the past two years, have you been convicted of any offense? Yes _____ No _____

If yes, please explain: _____

Are you currently involved in any of these legal situations?

Divorce proceedings _____ Child care/custody actions _____ Civil proceedings _____ Probation _____ Parole _____

Other: _____

FAMILY OF ORIGIN

Describe the personality and give characteristics for each of the following family members:

Mother: _____

Father: _____

Parental Figure/Stepmother: _____

Parental Figure/Stepfather: _____

Describe the relationship(s) between the above parents or stepparents: _____

Describe the personality and relationship with sibling(s): _____

What is your perception and awareness concerning your family of origin (the family you grew up in)? _____

Describe any particular event or person that had a significant effect on your life: _____

Compulsive/addictive behaviors in the family? (alcohol/drugs, sex, eating disorder, gambling, etc.)

Yes _____ No _____

Father _____ Mother _____ Father's Parents _____ Mother's Parents _____ Siblings _____ Other _____

History: _____

Present Status: _____

Effect on you: _____

RELATIONSHIP AND CURRENT FAMILY CIRCUMSTANCES

Current Status: Single _____ Married _____ Committed _____ Divorced _____ Separated _____ Widowed _____
How Long? _____

Number of Marriages/Committed Relationships: First M / CR Your Age _____
(Please circle Marriage –M Committed – CR) Second M / CR Your Age _____
Third M / CR Your Age _____

Reason for relationship ending (include ending date(s)):

First _____

Second _____

Third _____

(use separate sheet if additional space is needed)

Quality of relationship with your present partner: _____

Children (names and ages): _____

Relationship with children: _____

Please notify us if you are or think you may be pregnant.

DATING AND SEXUAL HISTORY

Early dating patterns: _____

Sexual Orientation: Heterosexual _____ Homosexual _____ Bi-sexual _____

Please check any of the following which you may have experienced, and your inclusive ages:

- 1) From _____ to _____ Sexually active
- 2) From _____ to _____ Abortions(s)
- 3) From _____ to _____ Affairs(s) – Current partner aware? Yes _____ No _____
- 4) From _____ to _____ Pornography: internet, movies, photographic, literature
- 5) From _____ to _____ Fetishism (sexual gratification by objects)
- 6) From _____ to _____ Prostitution
- 7) From _____ to _____ Masturbation – Self
- 8) From _____ to _____ Sexual Anorexia
- 9) From _____ to _____ Menopause
- 10) From _____ to _____ Impotence
- 11) From _____ to _____ Group Sex
- 12) From _____ to _____ Perpetrator of sexual abuse (Explain on separate sheet)
- 13) From _____ to _____ Victim of sexual abuse

Other: _____

THERAPY HISTORY

Have you ever been treated inpatient for an addictive disorder? Yes _____ No _____
 Disorder (drugs/alcohol, sex, gambling, eating disorder, etc.) _____

Where: _____ When: _____

Length of stay: _____

Length of Sobriety/Abstinence: _____

*If more than one treatment, please list on a separate sheet.

Have you ever received individual, couples, family outpatient counseling? Yes _____ No _____

1) Counselor: _____ When: _____

Length of Treatment: _____ For: _____

2) Counselor: _____ When: _____

Length of Treatment: _____ For: _____

*If more than two counselors, please list on a separate sheet.

Have you ever been hospitalized for a psychiatric diagnosis? Yes _____ No _____

Diagnosis: _____ Psychiatric Facility: _____

Where: _____ When: _____

Length of Stay: _____

*If more than one hospitalization, please list on a separate sheet.

CHEMICAL HISTORY

ALCOHOL

Age at first use? _____ Age at first intoxication? _____ Last use? _____

Current pattern of use: daily _____ weekends _____ binge _____ days per week _____ none _____

What do you prefer to use? _____ Amount consumed in 24 hours: _____

Number of years using? _____ Number of years heavy using? _____ Longest period of abstinence? _____

DRUGS

Have you ever used any drug not prescribed by a doctor? Yes _____ No _____

Have you used any of the following drugs? If so, state how often/amount and date of last use:

	Frequency/Amount	Year(s) Used	Date Last Used
_____ Marijuana	_____	_____	_____
_____ Cocaine	_____	_____	_____
_____ Heroin	_____	_____	_____
Name	Frequency/Amount	Yrs. Used	Date Last Used
_____ Sedatives	_____	_____	_____
_____ Diet Pills	_____	_____	_____
_____ Stimulants	_____	_____	_____
_____ Other Narcotics	_____	_____	_____
_____ Hallucinogens	_____	_____	_____
_____ Over the counter	_____	_____	_____
_____ Antihistamines	_____	_____	_____

Due to alcohol or drugs, have you experienced: blackouts____delirium____convulsions____seizures____
hallucinations____legal complications____ (check those that apply)

Do you see your drinking or drug use have a negative effect on your: family life____social life____
physical condition____emotional condition____finances____job____reputation in the community____
(check those that apply)

I believe I am an alcoholic and/or addict: Yes____No____Don't know____

NICOTINE HISTORY

Do you now smoke or use smokeless tobacco products? Yes____No____Product:_____

Years used?_____Current use/amount:_____

COMPULSIVE BEHAVIORS AND EMOTIONAL FACTORS

How much concern do you have about yourself regarding the following:

	Extreme	Frequent	Periodic	Minimal	Not at all
Overeating	_____	_____	_____	_____	_____
Under eating or dieting	_____	_____	_____	_____	_____
Purging/vomiting	_____	_____	_____	_____	_____
Binge eating	_____	_____	_____	_____	_____
Exercising or running	_____	_____	_____	_____	_____
Weight or body	_____	_____	_____	_____	_____
Relationship dependency	_____	_____	_____	_____	_____
Alcohol use	_____	_____	_____	_____	_____
Drug use	_____	_____	_____	_____	_____
Sexual thoughts/behavior	_____	_____	_____	_____	_____
Internet pornography	_____	_____	_____	_____	_____
Other pornography	_____	_____	_____	_____	_____
Care taking behaviors	_____	_____	_____	_____	_____
Perfectionism	_____	_____	_____	_____	_____
Gambling	_____	_____	_____	_____	_____
Money/finances	_____	_____	_____	_____	_____
Rigid/compulsive religion	_____	_____	_____	_____	_____
Isolating behaviors	_____	_____	_____	_____	_____
Nicotine use	_____	_____	_____	_____	_____
Physical health/illness	_____	_____	_____	_____	_____
Working/busyness	_____	_____	_____	_____	_____
Self-worth	_____	_____	_____	_____	_____
Spirituality	_____	_____	_____	_____	_____
Rage	_____	_____	_____	_____	_____

SELF EVALUATION

How do you picture yourself? (Describe yourself in your own words) _____

What are your strengths? _____

Do you have fears or anxieties about anything? Yes _____ No _____ If yes, please explain: _____

What major losses have you experienced in your life? _____

Have you ever had:

Suicide thoughts Yes _____ No _____ When: _____

Suicide plans Yes _____ No _____ When: _____

Suicide attempts Yes _____ No _____ When: _____

Self injury behavior (cutting, scratching, etc.) Yes _____ No _____ When: _____

Please explain any yes answers: _____

What would you like to change in your life? _____

How do you think the Healing Trauma Program can help you? _____

Please describe your relationship with food during the following ages:

0-10: _____

11-17 _____

18-26: _____

27-35: _____

36-44: _____

45-current: _____

SEX AND LOVE ADDICTION

The following questions are designed to be used as guidelines to identifying possible signposts of sex and love addiction.

YES NO

- | | | | |
|-------|-------|-----|---|
| _____ | _____ | 1. | Have you ever tried to control how much sex to have or how often you would see someone? |
| _____ | _____ | 2. | Do you find yourself unable to stop seeing a specific person even though you know that seeing this person is destructive to you? |
| _____ | _____ | 3. | Do you feel that you don't want anyone to know about your sexual or romantic activities? Do you feel you need to hide these activities from others – friends, family, co-workers, Counselors, etc.? |
| _____ | _____ | 4. | Do you get "high" from sex and/or romance? Do you crash? |
| _____ | _____ | 5. | Have you had sex at inappropriate times, in inappropriate places, and/or with inappropriate people? |
| _____ | _____ | 6. | Do you make promises to yourself or rules for yourself concerning your sexual or romantic behavior that you find you cannot follow? |
| _____ | _____ | 7. | Have you had or do you have sex with someone you don't (didn't) want to have sex with? |
| _____ | _____ | 8. | Do you believe that sex and/or a relationship will make your life more satisfying? |
| _____ | _____ | 9. | Have you ever felt that you <i>had</i> to have sex? |
| _____ | _____ | 10. | Do you believe that someone can "fix" you? |
| _____ | _____ | 11. | Do you keep a list, written or otherwise, of the number of partners you've had? |
| _____ | _____ | 12. | Do you feel desperation or uneasiness when you are away from your lover or sexual partner? |
| _____ | _____ | 13. | Have you lost count of the number of sexual partners you've had? |
| _____ | _____ | 14. | Do you feel desperate about your need for a lover, sexual fix, or future mate? |
| _____ | _____ | 15. | Have you or do you have sex regardless of the consequences (e.g. the threat of being caught, the risk of contracting herpes, gonorrhea, AIDS, etc.)? |
| _____ | _____ | 16. | Do you find that you have a pattern of repeating bad relationships? |
| _____ | _____ | 17. | Do you feel that your only (or major) value in a relationship is your ability to perform sexually, or provide an emotional fix? |
| _____ | _____ | 18. | Do you feel like a lifeless puppet unless there is someone around with whom you can flirt? Do you feel that you're not "really alive" unless you are with your sexual/romantic partner? |
| _____ | _____ | 19. | Do you feel entitled to sex? |
| _____ | _____ | 20. | Do you find yourself in a relationship that you cannot leave? |
| _____ | _____ | 21. | Have you ever threatened you financial stability or standing in the community by pursuing a sexual partner? |
| _____ | _____ | 22. | Do you believe that the problems in your "love life" result from: not having enough of, or the right kind of sex, or from continuing to remain with the "wrong" person? |
| _____ | _____ | 23. | Have you ever had a serious relationship threatened or destroyed because of outside sexual activity? |
| _____ | _____ | 24. | Do you feel that life would have no meaning without a love relationship or without sex? Do you feel that you would have no identity if you were not someone's lover? |

YES NO

- | | | | |
|-------|-------|-----|---|
| _____ | _____ | 25. | Do you find yourself flirting or sexualizing with someone even if you do not mean to ? |
| _____ | _____ | 26. | Does your sexual and/or romantic behavior affect your reputation? |
| _____ | _____ | 27. | Do you have sex and/or “relationships” to try to deal with, or escape from life’s problems? |
| _____ | _____ | 28. | Do you feel uncomfortable about your masturbation because of the frequency with which you masturbate, the fantasies you engage in, the props you use, and/or the places in which you do it? |
| _____ | _____ | 29. | Do you engage in the practices of voyeurism, exhibitionism, etc., in ways that bring discomfort or pain? |
| _____ | _____ | 30. | Do you find yourself needing greater and greater variety and energy in your sexual or romantic activities just to achieve an “acceptable” level of physical and emotional relief? |
| _____ | _____ | 31. | Do you need to have sex, or “fall in love” in order to feel like a “real man” or a “real woman”? |
| _____ | _____ | 32. | Do you feel that your sexual and romantic behavior is about as rewarding as hijacking a revolving door? Are you jaded? |
| _____ | _____ | 33. | Are you unable to concentrate on other areas of your life because of thoughts or feelings you are having about another person or about sex? |
| _____ | _____ | 34. | Do you find yourself obsessing about a specific person or sexual act even though these thoughts bring pain, craving or discomfort? |
| _____ | _____ | 35. | Have you ever wished you could stop or control your sexual and romantic activities for a given period of time? Have you ever wished you could be less emotionally dependent? |
| _____ | _____ | 36. | Do you find the pain in your life increasing no matter what you do? Are you afraid that deep down you are unacceptable? |
| _____ | _____ | 37. | Do you feel that you lack dignity and wholeness? |
| _____ | _____ | 38. | Do you feel that your sexual and/or romantic life affects your spiritual life in a negative way? |
| _____ | _____ | 39. | Do you feel that your life is unmanageable because of your sexual and/or romantic behavior or your excessive dependence needs? |
| _____ | _____ | 40. | Have you ever thought that there might be more you could do with your life if you were not so driven by sexual and romantic pursuits? |

**Sex and Love Addiction Questionnaire provided by The Meadows*

SEXUAL ANOREXIA ASSESSMENT

Check the following diagnostic criteria as part of your assessment for sexual anorexia.

- _____ 1. Recurrent pattern of resistance or aversion to any sexual activity, initiative or behavior.
- _____ 2. Persistent aversion to sexual contact even though it is self-destructive or harmful to relationship.
- _____ 3. Extreme efforts to avoid sexual contact or attention including self-mutilations, distortions of body appearance or apparel, and aversive behavior.
- _____ 4. Rigid, judgmental attitudes towards personal sexuality and sexuality of others.
- _____ 5. Extreme shame and self-loathing about sexual experiences, body perceptions, and sexual attributes.
- _____ 6. Sexual aversion affecting work, hobbies, friends, family and primary relationship.
- _____ 7. Preoccupations and obsession with avoiding sexual contact and with sexual intentions of others.
- _____ 8. Despair about sexual adequacy and functioning.
- _____ 9. Avoiding intimacy and relationships out of fear of sexual contact.
- _____ 10. Distress, anxiety, restlessness, or irritability because of sexual contact or potential sexual contact.

**Sexual Anorexia Assessment provided by The Meadows*

SEXUAL BEHAVIOR PROBLEM LIST

The following is a list of sexual behaviors which have been problems for our clients. Please review the list and check any behavior which has been a problem for you in the past or present. Remember that while it may be very hard to talk about these sexual issues, we hear these stories all the time and we need to know as much as we can in order to help you. Please check all that apply.

.....
Ages:

- | | | | |
|------------|--|------------|--|
| ___ to ___ | masturbation | ___ to ___ | use of objects or fetishes with sex |
| ___ to ___ | masturbation in a car | ___ to ___ | use of drugs with sex |
| ___ to ___ | masturbation to point of injury | ___ to ___ | using urination for sexual arousal |
| ___ to ___ | sexual obsession and fantasy | ___ to ___ | sexual asphyxiation with a partner |
| ___ to ___ | romantic involvements | ___ to ___ | asphyxiation with self |
| ___ to ___ | affairs, multiple relationships | ___ to ___ | use of force with sex |
| ___ to ___ | one-night stands | ___ to ___ | use of drugs to obtain sex |
| ___ to ___ | voyeurism | ___ to ___ | trading drugs for sex |
| ___ to ___ | pornography | ___ to ___ | sex with clients |
| ___ to ___ | strip bars/shows | ___ to ___ | sex with employers |
| ___ to ___ | exhibitionism | ___ to ___ | sex with family members other than your partner |
| ___ to ___ | use of prostitutes, escorts or massage parlors | ___ to ___ | sex with professionals (clergy, physicians, attorneys, etc.) |
| ___ to ___ | working as a stripper | ___ to ___ | sex with superiors at work |
| ___ to ___ | working as a prostitute | | |
| ___ to ___ | obscene calls | | |
| ___ to ___ | 900 or phone sex calls | | |
| ___ to ___ | inappropriate touching | | |
| ___ to ___ | anonymous sex | | |
| ___ to ___ | violent or dangerous sex | | |
| ___ to ___ | cybersex in any form | | |
| ___ to ___ | sex with a minor | | |
| ___ to ___ | sado-masochism | | |
| ___ to ___ | cross-dressing | | |

Other behaviors not listed: _____

**Sexual Compulsivity Assessment provided by The Meadows*

CELIBACY CONTRACT

In attending the Healing Trauma Issues Program, I agree to abide by the conditions of this contract.

CONDITIONS:

- NO MASTURBATION
- NO SEDUCTIVE BEHAVIOR
- NO PORNOGRAPHIC MATERIAL
- NO SEXUAL CONTACT WITH ANOTHER PERSON
- REPORT SEXUAL FANTASIZING TO APPROPRIATE STAFF

The purpose of this contract is to help remove sexually dependent behaviors, cope with fantasy, and link me back to future healthy sexuality.

Adherence to this contract may result in a recall of many childhood memories. Anxiety will probably increase, as I will be unable to use sexual behavior as a coping mechanism. The staff is here to assist me, and is aware of reactions to celibacy; they are here for my support.

With this contract for the benefit of my recovery, I am choosing to not allow myself that legal and human right to conjugal visitation.

This contract is in effect for the length of my stay at Onsite.

Client Signature

Date

Staff Signature

Date

**HEALING TRAUMA PROGRAM
MEDICAL HISTORY**

Instructions: Please check YES or NO if you are CURRENTLY experiencing any of the following:

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Frequent indigestion	<input type="checkbox"/> <input type="checkbox"/> Currently pregnant
<input type="checkbox"/> <input type="checkbox"/> Difficulty seeing	<input type="checkbox"/> <input type="checkbox"/> Heartburn or gas	<input type="checkbox"/> <input type="checkbox"/> Sores that don't heal
<input type="checkbox"/> <input type="checkbox"/> Difficulty hearing	<input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> Current injuries
<input type="checkbox"/> <input type="checkbox"/> Do you use a hearing aid?	<input type="checkbox"/> <input type="checkbox"/> Loss of appetite	<input type="checkbox"/> <input type="checkbox"/> High blood pressure
<input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> Abdominal pain, cramping	<input type="checkbox"/> <input type="checkbox"/> Irregular heart beat
<input type="checkbox"/> <input type="checkbox"/> Weakness, tiredness	<input type="checkbox"/> <input type="checkbox"/> Weight loss	<input type="checkbox"/> <input type="checkbox"/> Chest pain
<input type="checkbox"/> <input type="checkbox"/> Difficulty with coordination	<input type="checkbox"/> <input type="checkbox"/> Weight gain	<input type="checkbox"/> <input type="checkbox"/> Shortness of breath
<input type="checkbox"/> <input type="checkbox"/> Limited movement	<input type="checkbox"/> <input type="checkbox"/> Joint pain	<input type="checkbox"/> <input type="checkbox"/> Vomiting blood
<input type="checkbox"/> <input type="checkbox"/> Nausea or retching	<input type="checkbox"/> <input type="checkbox"/> Wear a prosthetic device	<input type="checkbox"/> <input type="checkbox"/> Up at night to urinate
<input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> Use crutches, cane, walker	<input type="checkbox"/> <input type="checkbox"/> Difficulty sleeping

Check below if anyone in your immediate family, currently or historically, has had the following:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Other Addictions/Compulsions
<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other Chronic Medical Conditions	

Historical Adult Weight: _____	Current Weight _____	Current Height _____
Maximum Weight _____	Age _____	Minimum Weight _____
		Age _____

Have you had any of the following?

YES NO	YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> <input type="checkbox"/> Mental Illness	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Gonorrhea
<input type="checkbox"/> <input type="checkbox"/> Seizures	<input type="checkbox"/> <input type="checkbox"/> Polio	<input type="checkbox"/> <input type="checkbox"/> Stroke	

Positive TB Skin Test (If yes, explain follow-up treatment): _____

Heart Disease (Describe treatment or testing history): _____

Allergies (Describe): _____

Other (Explain): _____

Do you have any other medical condition about which we should be aware? YES NO If yes, explain: _____

Date of last physical examination: _____

Date last treated by a physician: _____

Prior Hospitalization (excluding any treatment mentioned previously in this assessment):

Year _____ Name of Hospital _____
 Location of Hospital _____
 Diagnosis/treatment/operations _____

Year _____ Name of Hospital _____
 Location of Hospital _____
 Diagnosis/treatment/operations _____

 ONSITE CLINICAL SUPERVISOR

 DATE

HEALING TRAUMA PROGRAM CONTRACT AGREEMENT (MUST BE SIGNED TO COMPLETE ASSESSMENT)

By signing below, I acknowledge that I have read, understand, and agree to the following terms and conditions that will be in effect before, during, and after my involvement with Onsite's Healing Trauma Program and its program guidelines.

I agree to accept the concept of a chemical-free existence during the program. This means abstinence from all mind and mood affecting drugs and chemicals (excluding those prescribed by a physician), including alcohol, nicotine, and marijuana, during this period of time. I understand that any use of these chemicals will result in my discharge from the program. Since this is a nicotine-free program, participants who smoke or use tobacco in other forms will address their nicotine use as a part of this program. I understand I will be required to abstain upon my arrival to the program and throughout my stay at the site.

I understand this is a prepaid program, and I agree to meet all financial requirements at time of registration of the program. In addition to Onsite's pre-program registration and cancellation fee policies, I understand the program is on a "fee for service" basis. This means that since Onsite has made prior arrangements and incurred costs to provide said services for me, I will not be entitled to or receive a refund of any fees I have paid for any reason, even if I do not participate in or receive all of the services scheduled for me. Whether I complete the program as scheduled, or I am discharged from, or I discharge myself from the program before its completion, I understand I will not be entitled to or receive a refund of any portion of the prepaid program costs, including transportation to or from the program site.

I understand that seeking and receiving insurance reimbursement is solely my responsibility and not the responsibility of Onsite. Onsite does not provide DSMIV psychological diagnosis or CPT codes to insurance companies.

I understand and accept that Onsite makes no explicit or implied guarantees or warranties as to my successful completion of the program, the quality of my experience during the program, or my post-program experiences directly or indirectly resulting from my participation in the program.

I understand my participation in this program is voluntary, and the program may be physically and emotionally intense. I agree to accept such risks and I assume responsibility for such stress/distress and/or other effects of my participation. I hereby release, discharge and hold harmless Onsite and all of its staff of and from any and all claims, causes of action, demands, or judgments arising out of or in any way connected with my participation in the Onsite Healing Trauma Program and all related activities, including those arising out of the negligence of any of the aforementioned parties. I understand that participation in any of these activities contains certain risks of physical injury or death. I agree to assume fully the risk of injury or death arising from any such activity including but not limited to the climbing wall and wild woozie.

I understand I have the responsibility of assuming a leadership role regarding my own care and safety in this workshop.

As a condition of acceptance in the program, I agree to provide my complete medical history as provided for by the form entitled Healing Trauma Program Medical History and incorporated herein as if fully set forth in this contract.

I understand and agree that it may be necessary to make my medical history available to a hospital, physician or other health care provider in the event that I am in need of medical treatment; therefore, I authorize Onsite to release my medical history for that purpose. In the event of any medical emergency, I hereby authorize and give my full consent to Onsite Healing Trauma Issues Program personnel to take all appropriate measures to provide me with medical assistance including, if appropriate, permission to transfer me to another facility. I also authorize Onsite to contact any of my current or former health care providers and family members should the Healing Trauma Issues Program staff believe it is in my best interest to do so.

I understand that my participation in the program will involve interaction with other program participants who may have a contagious/infectious disease which may include but are not limited to known and unknown flu viruses, Hepatitis, HIV, bacterial infections, etc. and that Onsite takes universal precautions for the safety of all participants. I agree to assume the risk of such exposure and I agree to hold Onsite harmless and free from any and all claims, including reasonable attorney fees.

I understand that animals, including dogs, cats, and horses, inhabit the Onsite property with some of the animals being rescued and rehabilitated, and that interaction with these animals may result in injury as a result of negligence by myself or others, due to the unpredictable nature of animals. I also understand that with Onsite being located on a ranch, sometimes stray animals will come onto the property and that Onsite is not liable for any injury.

Name: _____

I understand that firearms, ammunition, or dangerous weapons are not allowed on property at any time. A gun permit does not authorize a participant or visitor to bring firearms onto Onsite's property or any buildings under any circumstances.

I agree to not engage in any activity that may cause damage to Onsite property. If damage does occur, I agree to pay full amount of damages. I also agree to not remove any of Onsite's property (including but not limited to pillows, blankets, etc) from the rooms and understands that if objects are removed, I am financially responsible for replacing missing objects.

I have fully and truthfully disclosed all information regarding my medical and physical history, including any medical conditions and medications which I am currently taking, whether prescribed or not.

I have fully and truthfully completed the program assessment, and any other documents which the program staff has provided to me.

The program will take place in a retreat setting. As such, I understand that the program participants, including myself, are not in a licensed health care setting or facility and will not receive medical supervision or monitoring. The program experience is designed to promote wellness and improve the ability of participants to function in a healthier manner emotionally, spiritually and psychologically. The program experience is not a substitute for inpatient, or extended outpatient treatment.

I will not reveal or discuss outside of any group process anything that happens or is said or done within any group process. I will not reveal the identities of any participants, family members or program participants who are or may have been at Onsite. I understand that violation of this confidentially pledge will be grounds for immediate dismissal from any/all Onsite programs, and may subject me to civil and/or criminal penalties.

I understand that Onsite operates under strict privacy policies, but group members will keep strict confidentiality.

I understand the Onsite cannot completely control the nature of information participants may reveal about themselves in the group process.

I have reviewed this agreement and the Healing Trauma Program guidelines carefully. I have been informed, to my satisfaction, as to what may occur during the Healing Trauma Issues Program.

This contract contains the entire agreement between the parties hereto, and its terms are contractual and not a mere recital. I further state that I have carefully read the foregoing terms & conditions, know the contents thereof, and I sign the same as my own free act.

I hereby agree to accept and abide by the policies, guidelines, conditions, and procedures as set forth in this agreement and the Healing Trauma Issues Program guidelines.

Signature

Date

INFORMATION CONCERNING YOUR HEALTH RECORDS

As of April 14, 2003, HIPAA—Health Insurance Portability and Accountability Act of 1996—goes into effect, requiring Onsite Workshops to provide you with this information which outlines the privacy practices we have in place to safeguard your Health Information. The following information is specifically about Onsite Workshops. This organization does not file insurance claims.

Privacy of Your Health Records

Your confidential information is kept private, under lock and key, and the building is protected by an alarm system. It is also stored electronically with security measures. Information contained in your files includes the assessment forms you completed, therapist and progress notes, screening results (if any), record of payment, aftercare plans, and any correspondence with Onsite before or after the program. You may have access to your file at any time. A reasonable fee will be charged to provide you with copies of your file. Your records file will be completely destroyed seven years after the latest attended program. Your name, program and contact information will be kept indefinitely.

Use and Disclosure of Your Health Records

Use (using your health information in the normal course of providing services and receiving payment) and disclosure (providing your health information to parties outside Onsite Workshops) may occur as a result of the following:

1. Occasionally, upon your special request, Onsite will provide a statement to you that documents your dates of attendance, tuition cost, room and board cost and payments made by you. We will not provide this directly to a third party.
2. You give written consent.
3. If there is clear and immediate danger to you or to someone you could endanger, or indication of abuse to minors. In such extreme cases, information would be given only to appropriate family members, professional workers, public authorities or threatened persons. Onsite will make great attempts to first discuss any such concerns with you and let you know what steps you need to take, before sharing information about you with others.
4. In the course of conducting programs, Onsite Workshops will share your health information with consulting clinical staff. These Business Associates are under contract and bound by the same laws and rules of confidentiality as Onsite. They are also subject to stringent professional rules of ethics. Employees of the facility where our programs are conducted have access to names only and no other health information, other than any medical food needs during the program.

Email and Cell Phone

Please be aware that when you share information with Onsite via email, Onsite cannot guarantee the confidentiality of that information, because of the nature of the Internet. Receiving an email from you will be understood as permission to respond to you by email. Giving us your email implies consent to contact you via email regarding upcoming programs or administrative concerns. This implied permission may be revoked by you at any time by contacting us by phone, email, or in writing. No personal health information will be transmitted unless it is in response to your email to us.

Cell phones are not a guarantee of privacy in communicating. When you contact our office during office hours, you may or may not be calling a cell phone. The supervisor's emergency phone, carried during non-office hours during programs is a cell phone.

Authorization Information

When information is required from a treatment provider, such as your therapist or doctor, Onsite needs your written permission to make contact. This may be a requirement for workshop admission and is found on the workshop assessment form you complete prior to admission to a workshop. This authorization limits information exchange to 3 months. You may revoke this authorization at any time.

Questions and Complaints

Onsite's privacy officer is Diana Nolen. She may be reached at 1-800-341-7432 or by email at diana@onsiteworkshops.com

If you are concerned that we may have violated your privacy rights, or you disagree with our handling of your health information you may complain to the above privacy officer. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for filing your complaint with the USDHHS upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Onsite Workshops reserves the right to change our privacy practices and the terms of this Notice at any time. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our notice at any time by contacting the privacy officer.

I acknowledge that I have received a copy of the information given above.

Signature _____ **Date** _____

ONSITE FINANCIAL AGREEMENT

PAYMENT:

This is a prepaid program. The full program cost must be paid at time of registration of the program before you will be admitted. We accept MasterCard, Visa and Discover at registration. No refunds are available (see cancellation section). Your program fee covers double or triple occupancy lodging, program fees, on-campus meals, and all activities

Program Cost \$ 4600.00

CANCELLATIONS

For all programs, except Individual, Couples, and Family Intensives and Montana Equine, if a cancellation occurs 14 or more days prior to a program's start date, the full amount, less \$500 processing fee per person, will be refunded. For Individual, Couples, and Family Intensives and Montana Equine, half of the program fee is non-refundable. If a cancellation occurs less than 14 days before the program's start date, the entire amount will be non-refundable. No refunds are given for any program if a participant does not attend, leaves the program early, or completes the program.

TRANSFERS

For all programs, except Individual, Couples, and Family Intensives and Montana Equine, participants must submit a request to be transferred in writing 14 days prior to the program start date. Transferring to another program will incur a \$100 per person processing fee. Participants will not be permitted to transfer unless the request has been received and approved. For Individual, Couples, and Family Intensives and Montana Equine, no transfers will be permitted.

I understand this is a prepaid program, and I agree to meet all financial requirements at time of registration of the program. In addition to Onsite's pre-program registration and cancellation fee policies, I understand the program is on a "fee for service" basis. This means that since Onsite has made prior arrangements and incurred costs to provide said services for me, I will not be entitled to or receive a refund of any fees I have paid for any reason, even if I do not participate in or receive all of the services scheduled for me. Whether I complete the program as scheduled, or I am discharged from, or I discharge myself from the program before its completion, I understand I will not be entitled to or receive a refund of any portion of the prepaid program costs, including transportation to or from the program site.

Participant Name (Please Print): _____

Participant Signature: _____ **Date:** _____

Signature of Cardholder (if different from participant): _____

PROGRAM PAYMENT INFORMATION

Dear Participant:

Please fill out the information below, and also indicate how you will be paying for the program. Once completed, send this back with your program materials.

Thank you!

Please print or type

Name of Person(s) Attending Program: _____

Name of Program Being Attended: _____

Dates of Program: _____ **Cost of Program:** \$4600.00

Please Circle Method of Payment:

Credit Card

Personal Check

Cashier's Check

Money Order

Note: if paying with check or money order, we will not be able to reserve your space in the program until payment has been received.

Credit Card #: (Visa, MasterCard, or Discover) _____

Credit Card ID # (number located on back of Visa, MasterCard and Discover Cards): _____ **Expires:** _____

Name on Card: _____

Billing Address for Card: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Total to be processed on card: _____

CANCELLATIONS

For all programs, except Individual, Couples, and Family Intensives and Montana Equine, if a cancellation occurs 14 or more days prior to a program's start date, the full amount, less \$500 processing fee per person, will be refunded. For Individual, Couples, and Family Intensives and Montana Equine, half of the program fee is non-refundable. If a cancellation occurs less than 14 days before the program's start date, the entire amount will be non-refundable. No refunds are given for any program if a participant does not attend, leaves the program early, or completes the program.

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Signature of Cardholder: _____ **Date:** _____

GROUND TRAVEL ARRANGEMENTS

(Bring this sheet with you as you travel, for phone numbers and addresses)

If you need to contact Onsite to advise of delays or problems on your day of travel, please use the following numbers:

Before 5:00 p.m. CST: (800) 341-7432

Before 5:00 p.m. CST: (615) 789-6609

After 5:00 p.m. CST: (615) 417-4733

PLEASE READ THE FOLLOWING TRAVEL INFORMATION CAREFULLY.

Because of the distance to the program site and limited economical transportation options, it is necessary to schedule your flight times in order to utilize the Onsite shuttle service described below. If you believe that there is any chance that you will be delayed (weather, close connections, etc.), we strongly suggest that you travel in to the Nashville area a day early.

We recommend you use our shuttle service or rent a car for your transportation to Onsite.

AIRPORT TO ONSITE:

You will be responsible for your own transportation to/from the airport to the Onsite campus. To assist you, Onsite has arranged scheduled shuttle service for your ground transportation needs. If you choose to take our shuttle, please arrive at the Hotel Shuttle pickup area located outside the bottom level of the airport **15 minutes** prior to scheduled departure times. There are signs located throughout the airport to direct you to the Hotel Shuttle pickup area. There is also an information desk on the baggage claim level to direct you to the Hotel Shuttle pickup area. The Hotel Shuttle pickup area is located on the bottom level of the airport, one level below the baggage claim area. Exit the airport on the bottom level (where rental car agencies are located), cross at the first crosswalk, turn left and look for a large, white shuttle with an "Onsite Workshops" sign on the passenger door. **Remember, due to airport regulations, the shuttles can arrive for loading only 5 minutes prior to the departure times listed below.**

SHUTTLE GROUP # 1: 12:30 P.M.
SHUTTLE GROUP # 2: 3:30 P.M.

If you arrive at the airport after the last scheduled shuttle time of 3:30 p.m., you will need to make your own arrangements for transportation to the Onsite campus via taxi or rental car. The address is: 1044 Old Highway 48 North, Cumberland Furnace, TN 37051. **Checker Cab** is familiar with our facility, and they can be reached at (615) 497-3972 to arrange transportation. All major rental car agencies are also located at the Nashville Airport.

RETURN TRIP TO AIRPORT:

The shuttles will depart the Onsite campus to the Nashville Airport at 7:00 a.m. on the last day of the program. The trip takes from one to two hours, and because of lengthy airport check-in times, it is important not to schedule departing flights earlier than 10:00 a.m. If you schedule your departing flight earlier, you will be responsible for your own transportation back to the airport.

HAVE DELAYED BAGGAGE DELIVERED TO: THE DROUILLARD HOUSE, 1044 OLD HIGHWAY 48 NORTH, CUMBERLAND FURNACE, TN 37051. FOR AFTER HOURS DIRECTIONS, CALL (615)417-4733.

If you decide to fly into Nashville a day early for your program, here is a list of hotels located near the Nashville Airport for your convenience:

<u>HOTEL</u>	<u>PHONE</u>
Fairfield Inn	888/236-2427
Courtyard by Marriott	800/321-2211
Days Inn Airport	800/851-1962
Holiday Inn Express	615/883-1366
Ramada Inn Airport	800/272-6232
Hampton Inn	800/426-7866

AIR TRAVEL ARRANGEMENTS

REMINDERS:

- 1) DO NOT MAKE FLIGHT RESERVATIONS UNTIL YOU HAVE BEEN ACCEPTED INTO THE PROGRAM.
- 2) RETURN THE ARRIVAL INFORMATION BELOW, OR CALL/FAX/EMAIL THE ONSITE OFFICE WITH YOUR ARRIVAL AND DEPARTURE INFORMATION.
- 3) SCHEDULE YOUR FLIGHT TO ARRIVE AT THE NASHVILLE AIRPORT (BNA) BY 3:00 PM ON THE DAY YOUR PROGRAM BEGINS AND TO DEPART AT 10:00 A.M. OR LATER ON THE FINAL DAY OF YOUR PROGRAM.
- 4) YOU WILL BE RESPONSIBLE FOR YOUR OWN TRANSPORTATION IF YOU SCHEDULE YOUR ARRIVAL/DEPARTURE OTHER THAN THESE TIMES.
- 5) BRING THE PAGE TITLED "GROUND TRAVEL ARRANGEMENTS" AS IT CONTAINS CONTACT NUMBERS, SHUTTLE INFORMATION/DIRECTIONS, AND DELAYED LUGGAGE INSTRUCTIONS.

NAME: _____

PROGRAM: _____ DATE: _____

.....

ARRIVAL DATE AND TIME: _____

AIRLINE: _____ FLIGHT NUMBER: _____

_____ Yes, I will be on the 12:30 p.m. shuttle.

_____ Yes, I will be on the 3:30 p.m. shuttle.

_____ I have made other transportation arrangements

.....

DEPARTURE DATE TIME: _____

AIRLINE: _____ FLIGHT NUMBER: _____

_____ Yes, I will be on the 7:00 a.m. shuttle.

_____ I have made other transportation arrangements

***PLEASE CONTACT ONSITE WITH TRAVEL INFORMATION AT LEAST ONE WEEK PRIOR TO THE BEGINNING OF YOUR PROGRAM. THANK YOU.**

DRIVING DIRECTIONS TO ONSITE

Lost? Call (800) 341-7432 or (615) 789-6609

If after 5:00 p.m., call (615) 417-4733

From Nashville/Nashville Airport:

Take **I-40 West** towards **MEMPHIS**. Take Exit 192 (McCory Lane towards Pegram). Turn right onto McCory Lane and travel 1.2 miles. Turn left onto Hwy 70W and follow through Pegram to White Bluff for 13.5 miles. Turn right onto Hwy 47N. Go approximately 9.7 miles until you meet Hwy 48. Turn right onto Hwy 48N. At 3 way stop in Charlotte you will go approximately 6.4 miles. As soon as you pass the cemetery on the left you will see a large green sign that reads Cumberland Furnace on the right hand side. You will immediately take a left (veer down the hill to the left almost directly across from the sign). Turn left and go to the bottom of the hill. At the bottom of the hill you will see the word SLOW painted directly on the roadway. Directly on the left is the Onsite driveway. You will see a sign that reads Drouillard House and a steep blacktop drive which is fairly secluded. Proceed up the drive. Registration will be in the brown building behind the mansion on the left hand side of the drive.

From I-24 from the Northwest:

I-24 East to Exit 4 (Hwy. 79 Guthrie/Clarksville). Go right off the exit (Hwy. 79 South) onto Wilma Rudolph Blvd. It turns into College Street, and dead-ends in about 8 miles. Turn left onto Hwy. 41A South. Take this road 1.5 miles until it curves right immediately after the Shell Station (the sign will say Hwy 13 South towards Charlotte). This road turns into Hwy. 48 South. Stay on Hwy. 48 South for approximately 17.5 miles until the turnoff to Cumberland Furnace (marked by a big green sign). Turn right on New Dry Hollow Road, then take the first left, cross the bridge and take a right up the blacktop drive to the Drouillard House. Proceed up the drive and follow the signs to the Carriage House for registration.

From Memphis:

Take I-40 East out of Memphis towards Nashville. Exit 172 to Dickson. You will travel through Dickson on Hwy. 46 North about 5 miles until it dead-ends at a stoplight in front of Bart's BBQ at State Hwy. 70 (not Business Route 70). Turn left on Hwy. 70, travel approximately ¼ mile through the next stoplight. Take the next right (immediately after the stoplight) which will be Hwy. 48 North.

Follow Hwy. 48 North for about 7 miles, through the town of Charlotte. Approximately 6 ½ miles past Charlotte, look for the first large green sign to Cumberland Furnace. As soon as you see this sign, prepare to turn left on the next road. Turn left and go to the bottom of the hill. Across the street you will see a Drouillard House sign and a steep blacktop drive. Proceed up the drive and follow the signs to the Carriage House for registration.

