

Check-In Date: _____ Bed Number _____

Check-In Registration Form

Personal:

Name: _____
Cell Phone _____ Home Phone _____

Office Phone _____

Address: _____

City: _____ State _____
Zip Code _____

Email: _____ Gender: M / F Date of Birth: _____
Age: _____

Emergency Contact Name: _____

Relationship: _____
Cell Phone _____
Home Phone _____

Office Phone _____

Sponsor's Name (if one): _____
Cell Phone _____
Home Phone _____

Office Phone _____

Marital Status: _____ Ethnicity: _____

Children? YES / NO Ages: _____

Employed: YES / NO Employer: _____

Medical/Physical/Mental Health History:

Other than those problems associated with alcohol or chemical use, do you suffer from any other chronic physical or mental health issues of which we should be

aware? YES /NO

Explain _____

Are you currently under a physician's care? YES / NO

Physician's name: _____

Address: _____ Phone #: _____

Are you currently taking any medications? YES / NO What are they? _____

Food or Other Allergies? YES / NO List: _____

When did you have your last drink of alcohol? _____

Last use of your last mood altering chemical(s)? _____

What chemical(s) did you use? _____

What is your drug of choice? _____

Detox

How did you detox? _____

Name of Medical facility: _____

Date of Admission: _____ Discharge: _____

Name of Physician: _____

Have you ever had a seizure?

Have you ever been hospitalized for a psychiatric illness? YES / NO

Diagnosis:

Treatment History:

Is your admission to The Retreat voluntary? YES / NO

Have you been in treatment for alcoholism or chemical dependency previously?
YES / NO

How many times? _____ Date of last treatment:

Name of treatment facility?

Have you attended an AA meeting? YES / NO Date of introduction

Have you had any periods of sobriety? YES / NO

How long was your longest period of sobriety?

An important element of The Retreat is the recovery of the entire family. It is a family illness that requires a family solution. During the time that you are here we will have two family weekends. Who can we count on to participate from your family?

Do you have any questions? YES / NO If yes, please note:

By signing I agree all above information is complete and correct.

Guest signature: _____ Date:

Staff _____ Printed _____ name:

Staff Signature: _____ Date:

Family Program Release

Guest Name _____

Guest Number

Other Names Used _____

Birth Date

I authorize the Retreat to contact the following family member(s) to discuss the Retreat Family Program and related matters:

Renwal House NW

Relation: _____
dba The Taylor Made Retreat

Name: _____
10930 SW Walker Road

Address: _____
Beaverton, OR 97005

AND

Phone: (971) 249-3840
Phone: _____

Fax: N/A
Email: _____

Mailed _____

Fax:

I understand that my chemical dependency records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my Mental Health records are afforded protection under state law. I understand that

I can revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent expires within one year of signature. I understand this communication will reveal my presence at The Retreat and/or The Residence.

GUEST
SIGNATURE _____ DATE _____

WITNESS/STAFF
SIGNATURE _____
DATE _____

CONDITIONS OF REGISTRATION

I, _____ (Date of Birth: ___/___/___) hereby apply to The Retreat as a guest in this non-clinical, supportive-educational program which is intended for those individuals who are recovering from alcoholism and chemical dependency. This application is subject to the conditions hereinafter set forth:

General Conditions

1. **CONSENT TO PARTICIPATE:** I hereby voluntarily consent to participate in The Retreat's Twelve Step-oriented, mutual-help, self-directed environment. The Retreat provides a safe, chemical free respite where members of the recovery community can study the spiritual principles of recovery as outlined in the Big Book of Alcoholics Anonymous. I am aware that no guarantees have been made to me as a result of my participation or examination at The Retreat.

2. **NO WARRANTY:** I understand that The Retreat does not warrant or agree to effect a cure or provide a rehabilitation or treatment experience, but merely to provide me a safe and supportive, mutual-help environment by which to share the principles of Alcoholics Anonymous with others involved in the Twelve-Step program of recovery. I understand that The Retreat provides no clinical and/or counseling services, e.g. assessment, individual or group counseling and is not a replacement for a clinical or therapeutic treatment experience.

3. **TRANSPORTATION:** The Retreat may provide transportation services to me. As a guest I assume responsibility for liability en route to/from, to the full extent of the law.

4. **ANONYMITY:** The Retreat adheres closely to the Alcoholics Anonymous tradition of anonymity. I am obliged to maintain anonymity and privacy of my fellow guests. Who you see here, what you hear here, let it stay here.

5. **EMERGENCY CONTACT:** I understand that when I provide The Retreat with an emergency contact, I am authorizing The Retreat to contact that person only to notify them of my emergency change of status or condition.

6. **RESPONSIBILITY:** The Retreat has no responsibility for any personal injury (mental or physical) which may be received by participation in sports, controlled exercise, or other recreational activities, or from participation in any activities of a guest at The Retreat and I agree to assume such responsibility to the full extent allowed by the law.

7. **CHARGES:** The Retreat charges for board and lodging, and the provision of a self-directed, mutual-help oriented Twelve-Step environment. Normal charges of The Retreat are itemized. That includes room and board, peer and A.A. volunteer-

led-Twelve-Step activities.

Guest Signature
Signature

Date Staff
Date

Registration Inspection Form

CONSENT TO SEARCH: The Retreat has a policy requiring a guests belongings be searched upon admission. Signing this document indicates the guests understanding of this policy and willingness to comply with it.

ITEMS REMOVED FROM GUEST BELONGINGS	Item Location
1. Alcohol/Items Containing Alcohol	
-	
-	
-	
2. Legal/RX Drugs Not Supervised	
-	
-	
-	
3. Illegal Drugs/Paraphernalia	
-	
-	
-	
4. Potential Weapons/Weapons	
-	
-	
-	
5. Other Items Disallowed By Policy	
-	
-	

GUEST SIGNATURE: _____ **CHECK-IN**
DATE: _____

IN-TAKE STAFF SIGNATURE: _____
DATE: _____

DISCHARGE
DISPOSITION (home, sober house, etc.?):

DISCHARGE STAFF SIGNATURE: _____
DATE: _____

Receipt of Information

I have received the Guest Handbook containing the following:

- **Program Goals and Rules**
- **Business Office Info**
- **Retreat Chores**
- **Expectations and Responsibilities**
- **Living Arrangements**
- **Daily Schedule**
- **Visiting Alumni and Volunteer Opportunities**
- **The Buddy System**
- **Security and Medical Emergency**
- **Fire Prevention and Safety**
- **Procedures for Management of Guest Property**

I have been oriented to the Retreat's rules, schedule, services, expectations and responsibilities.

Guest's Signature

Date

Information reviewed with the guest at this date:

Staff Signature

Date

Financial Plan

Guest Fees for The Retreat's 30-day program is \$4,900.

Guest Fees are due at the time of check-in with the balance payable within the first two weeks.

Our 30-day program has a non-refundable fee of \$2,830 for Guests who leave before their 16th day.

Guests that leave on day 16 or later will not receive a refund unless approved by the program staff.

Amount received \$ _____

Check # _____

CC type _____*

Cash \$ _____

Heart Amount \$ _____
\$ _____

Scholarship Amount

Financial arrangements:

Approved by:

Date _____

Date _____

Date _____

**Please complete credit card payment form.*

Please state name, address and phone number of the financially responsible person(s) or institution for non-routine costs (i.e. books, medical visits, medication, etc.):

Name

Street Address

City
Phone

State Zip

Email

Signature
Date