Thank you for your interest in Regaining Balance

Our mission is to offer women veterans tools that can make a difference and aid in recovery from the ravages of post-traumatic stress. Women partnered with veterans diagnosed with PTSD are invited to participate in retreats specificly created for wives/ female partners of veterans with PTSD. Veterans retreats are separate retreats.

What's needed to apply?

In order to be admitted to a Regaining Balance retreat you will need to have your current medical and mental healthcare providers sign off on your suitability for participation, which includes approval to engage in a retreat at a high-altitude location. (Mountain Gate, which serves as the retreat headquarters, is at approximately 7800 ft elevation.) You will also need to sign and send waivers allowing Regaining Balance staff to share with and receive information from these providers. As this may need to be done by mail and involves multiple parties, to assure program participation these forms should be completed and mailed to Regaining Balance as far in advance of the scheduled retreat as possible.

Please print and fill out the forms below. Please note that there are two places each (marked by an asterix) that require the signatures of your current providers of mental health and of medical services.

Following the application documents are three medical disclosure release forms. Please fill out these forms with the names of each of your current mental health and medical provider(s) so that Regaining Balance will be able to share information with these providers as necessary. (If you have only two providers, you will need to fill out only two of these forms.) *In accordance with federal guidelines designated by HIPAA, we will only be able to discuss your case with individuals and agencies for which you have provided us signed releases.*

In order for your application to be considered, ALL relevant forms must be completed and submitted with your application.

Finally, please mail the signed and completed documents (see the following seven pages) to Regaining Balance at the following address:

Regaining Balance
Mountain Gate
HCR 65 Box 78
Ojo Sarco NM, 87521-9604

If you have any questions or concerns about the application process don't hesitate to contact us at :

RegainingBalance@gmail.com or (505) 218-7836

We look forward to receiving your application.

Regaining Balance
Retreat Application

I am applying to the following Regaining Balance retreat (dates): _____

Name (please print) _____ Phone (H) (____) _____

(W) (____) _____ Cell (____) _____

Mailing Address _____ Zip Code _____

E-mail _____ Date of birth: _____

Emergency Contact (name & relationship) _____

Phone (H) (____) _____ (W) (____) _____ Cell (____) _____

Mental Health Provider Name & Contact information (*required) _____

(Please provide a signed copy of your provider's Release of Information form with this application.)

Mailing Address _____ Zip Code _____

Phone (____) _____

Mental Health Provider's Signature of approval to engage in the retreat (*required)

Signature_____

Primary Care Provider Name & Contact information (required) _____

(Please provide a signed copy of your provider's Release of Information form with this application.)

Mailing Address _____ Zip Code _____

Phone (____) _____

Primary Care Provider's Signature of approval to engage in the retreat (*required)

Signature_____

The Regaining Balance program involves a 3- or 4-day period of training **at high elevations** which includes outdoor walks, learning and practicing breathing techniques that may be applied indoors or outdoors, and sitting in silence for short periods of time. For more information consult the Regaining Balance website at: www.regainingbalance.org or contact us at:

RegainingBalance@gmail.com or by calling 505-218-7836; please leave a clear message and call back number if you don't reach one of us.

By signing this application, I agree as follows:

(1) I will take part in all program activities and finish the entire program.

(2) WAIVER OF LIABILITY: *I understand that this program takes place **at high altitude** and is a period of training including outdoor hikes, instruction in breathing and other meditation techniques shown to be helpful in dealing with PTSD, and walking and meditating in silence for periods of time. In accordance with this understanding and in consideration for my being accepted to this program, I agree that neither Regaining Balance, Mountain Gate nor any of its staff, officers or trustees—nor any person acting as program instructor or overseeing any aspect of the program—shall be liable for any loss or injury suffered by me in connection with my participation in this program, whether or not such loss or injury is caused by any act or omission of the Regaining Balance program or of any of the persons specified above. I also understand that no illegal substances, alcohol, or weapons of any kind are allowed at any place or time during the program.*

Signature _____ Date_____

Name (please print): _____Date: _____

MEDICAL INFORMATION (required)**:** This information is shared only with those directly involved in leading the program and will be kept confidential. *Please answer the following questions in detail, using additional paper if necessary. The purpose of this medical information is to help determine whether attendance at a Regaining Balance retreat might adversely affect an applicant's health. It also helps those conducting Regaining Balance retreats to be aware of any physical or mental conditions that may require special consideration. For this reason it is vital that all information be current and specific in regard to both active and inactive conditions. This medical information is solely for the instructors' reference. (If for some reason you must speak privately with one of the instructors, this can also be arranged.)*

1. Briefly describe any medical or psychiatric conditions you have that require regular care or medication.

2. Please list all conventional and unconventional medications you are currently taking under a doctor's prescription, and the reasons for their use. Use additional paper if this space is not sufficient. If you are prescribed any controlled substance, please list the prescribing physician(s), including contact information, and sign a release form as well for each physician along with your other health care and mental health care providers.

Medication:	Purpose:	Prescribing Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List any major surgeries you have had in the past 5 years; also list any body parts or major organs missing.

4. List any hospitalizations or institutionalizations (for any reason, for any length of time).

5. Describe any significant problems you are having with your back, neck, or legs.

6. Describe any other physical or mental conditions that may affect you or others in retreat such as chronic headaches, pregnancy or menstrual problems, or current illnesses.

7. All food served at Mountain Gate is vegetarian and gluten free. (There is an option, depending upon the time of year, where participants can, on the third day at lunch time, drive to a nearby town to have a nonvegetarian meal at their own cost. The Sugar Nymphs Bistro in Peñasco offers a 10% discount to Regaining Balance participants, and has very good food.) Please describe any other dietary considerations that might affect your participation. If you have food allergies, please give some indication of their seriousness.

8. Describe any other allergies (including allergic reactions to drugs).

9. Do you have any special needs? If so, please list here:

10. When possible we like to have a staff dog at the retreats. Please let us know if that creates any complications for you. We can make necessary adjustments if you let us know far enough in advance.

11. Please list your military service dates and branch(es) of service, and provide a copy of your DD214:

Name: _____ Date: _____

Please also notify us of any medical conditions that arise after you have submitted this application.
After completing this application ncluding release forms (see all pages), and obtaining the required signatures, sign and mail to:

Regaining Balance
Mountain Gate
HCR 65 Box 78
Ojo Sarco NM 87521-9604

Regaining Balance

Authorization for Release of
Confidential Information

Participant's Name: _____

Date of Birth: ____/_____/____

Address:_____

Telephone: _____

I authorize the exchange of information described below between Regaining Balance and the following agency(s) and/or individual(s):

- Healthcare provider(s)_____ (name)
- Agency(s) _____ (name)
- Other_____ (name)

This authorization applies to the following information:
(Check each line that applies)

X	Dates of service	X	Social/Developmental
X	History and Assessment	X	Psychological
X	Medical	_____	Other

Expiration: This authorization will automatically expire 365 days after date signed.

Restrictions: Providers who receive this information may not release it to someone else unless another authorization form is signed.

Your Rights: You may refuse to sign this form. You may cancel it at any time by informing Regaining Balance in writing. If you cancel your permission to allow the release of information, it will go into effect immediately (unless someone already released information). You have a right to receive a copy of this Authorization.

Signature _____ Date_____

Regaining Balance

Authorization for Release of
Confidential Information

Participant's Name: _____

Date of Birth: ____/_____/____

Address:_____

Telephone: _____

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