Admissions Packet

PARENT CHECKLIST

A. Forms signed & returned before placement or transportation occurs.
B. Immunization records must be included in admissions paperwork.
C. Copy of birth certificate must be included in admissions paperwork.
D. Current physician's orders or a copy of the current prescription with the physician's signature is required at the time of placement. No medication may be administered without this information. This information may be faxed by the physician's office to (435) 638-7582 or e-mailed to nursing@sorensonsranch.com
E. Interstate compact agreement filled out, signed, & forwarded to home state.
F. Copy of insurance cards, front & back must be included in admissions paperwork.
G. Pre-approval by insurance, if residential treatment benefits apply. Include all information obtained from insurance, i.e., name of case manager, phone number of case manager, and case number. (Check your benefits to see if you indeed do have coverage specifically for Residential Treatment Centers.)

FORMS

Parent Checklist
Application for Admission
Pharmacy Prescription Form
Intake & Assessment Forms
Power of Attorney
Medical Records Release
Signature Page
School Records Release
Confidential Release Forms
Insurance Release
Credit Card Charge Authorization
Interstate Compact Information
Individual Treatment Plan Input
Insurance Info for Residential Treatment Coverage
Progress Report Listing
Telephone & Mail Contact Listing

SORENSON'S RANCH SCHOOL
P. O. BOX 440219
KOOSHAREM, UT 84744
(435) 638-7318 FAX (435) 638-7582
email: admissions@sorensonsranch.com

Application For Admission
Insurance – Billing Information
Transportation Authorization

STUDENT#
ADMISSION DATE

THIS FORM MUST BE FILLED IN COMPLETELY! PLEASE MARK THROUGH WHAT DOES NOT APPLY.

Prior to the admission of student, this paperwork must be completed and returned. Student may be rejected by testing/intake committee up to 30 days after arrival at campus. A representative of SRS will contact the parent/s or caseworker within two weeks of admission to explain specifics of the program. Refund of all tuition not used will be made if student is rejected in testing.

STUDENT

APPLICANT/STUDENT'S NAME LAST	FIRST	MIDDLE						
ADDRESS OF APPLICANT/STUDENT CITY	STATE	ZIP CODE						
SOCIAL SECURTIY #	AGE	BIRTHDATE	PLACE OF BIRTH	SEX ☐ M ☐ F	HAIR COLOR	EYE COLOR	HEIGHT	WEIGHT
WAS APPLICANT ADOPTED? _____NO _____YES IF YES, AT WHAT AGE	RACE	RELIGION	GRADE LEVEL ENTERING					

FATHER

FATHER'S FULL NAME	ADDRESS		
PHONE _____HOME ____CELL	BIRTHDATE	SOCIAL SECURITY #	EMAIL ADDRESS
EMPLOYER ☐ FULL TIME ☐ PART TIME	ADDRESS OF EMPLOYER	TELEPHONE # OF EMPLOYER	

MOTHER

MOTHER'S FULL NAME	ADDRESS		
PHONE ____HOME ____CELL	BIRTHDATE	SOCIAL SECURITY #	EMAIL ADDRESS
EMPLOYER ___ FULL TIME __ PART TIME	ADDRESS OF EMPLOYER	TELEPHONE # OF EMPLOYER	

ARE PARENTS MARRIED ☐ NO & LIVING TOGETHER ☐ YES	IF NO, WHO HAS CUSTODY:	WHO IS STUDENT LIVING WITH CURRENTLY:	HOW DID YOU HEAR ABOUT US?

PAYMENT INFO

PLEASE PROVIDE NAME, ADDRESS & PHONE OF PERSON OR AGENCY RESPONSIBLE FOR PAYING MONTHLY TUITION

NAME OF PERSON BILLS ARE TO BE SENT TO:	RELATIONSHIP OR AGENCY	TELEPHONE	ALLERGIES:
ADDRESS CITY STATE ZIP			CURRENT MEDICATIONS:

MEDICAL BILLING

*** ATTENTION MEDICAL PROVIDERS: PLEASE USE THIS ADDRESS TO SEND ALL MEDICAL BILLS TO AFTER BILLING**

NAME OF PERSON BILLS ARE TO BE SENT TO	RELATIONSHIP	TELEPHONE
ADDRESS OF PERSON BILLS ARE TO BE SENT TO CITY	STATE	ZIP

*Please provide insurance information in the boxes below. This information will be provided to all medical facilities that treat your child, in order for your insurance billings to be correct the information below must be complete. Copies of the front and back of your insurance card are also required to accompany this form. Sorenson's Ranch School will not be responsible for any billing incurred due to missing or incorrect information.

MEDICAL INSURANCE

INSURANCE COMPANY	INSURANCE TELEPHONE	
CLAIMS ADDRESS		
POLICY HOLDER'S NAME	POLICY HOLDER'S SS#	POLICY HOLDER'S BIRTHDATE
GROUP #	POLICY# CONTRACT# ID#	EMPLOYER NAME / EMPLOYER PHONE

I/We, the undersigned, hereby certify that I/we have custody of applicant/student and that I/we take financial responsibility for all costs incurred during treatment. I/We further authorize any staff member of Sorenson's Ranch School to provide transportation or authorization/confirmation for emergency and/or medical treatment for my/our child listed above at any medical facility should it be deemed necessary. I/We understand this will be done on my/our behalf should I/we be unable to be contacted by Sorenson's Ranch School at time of said emergency.

_____ Father or Guardian's Printed Name

_____ Father or Guardian's Signature

_____ Mother or Guardian's Printed Name

_____ Mother or Guardian's Signature

Date Signing_____ 20_____ Hour_____

Date Signing_____ 20_____ Hour _____

Sorenson's Ranch School

Pharmacy
Insurance Form
360 South Main Street
Richfield, Utah 84701
(435) 896-5759

Please provide <u>all</u> of the following information to help the pharmacy staff process your prescriptions under your insurance.

Name of the student: _____

Date of birth of the student: _____/_____ Gender: _____

Allergies to any medications, prescription or over-the-counter: _____

Please list all current medications that the student is taking: _____

Does the student's current medical insurance have prescription coverage? _____

Name of the insurance carrier: _____

Name of the card holder on the insurance: _____

Cardholder identification number/Medicaid number: _____

Group number: _____

Person Code of the student (i.e. Cardholder is 01, spouse 02, 1st child 03, 2nd child 04, etc.):_____

The name of the parent(s) or guardian(s) to contact concerning prescription/insurance issues: _____

Telephone number for contact person:

Home: _____ Work: _____

We will do our best to process the prescriptions under your insurance; but please understand that some insurance companies do not contract with pharmacies in Utah. Please include a legible copy of the front and back of the current prescription card(s) to help us serve you better. If you have any questions, feel free to call at (435) 896-5759.

ORDERS FOR CURRENT MEDICATION

A current medication list and signature of prescribing physician must be sent prior to or with student when admitted to SRS. Medications will not be administered without this sheet. This includes any herbal or over the counter medication the student takes on a regular basis.

Student Name: _____

Is the student taking any over the counter or herbal medication regularly? _____YES _____NO
(If yes, please list below)

Current Medication	Dose	Schedule	Route
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician Comments: _____

_____

Print Physician's Name: _____

Physician's Signature: _____ Date: _____

MEDICATION HISTORY:
Please list any prior medications and the reason for discontinuing.

_____

_____

_____

_____

_____

_____

_____

_____

SORENSON'S RANCH SCHOOL
PARENT INITIAL INFORMATION FORM

Dear Parent/Guardian we ask that you please fill out the following information as completely, specifically, and timely as possible. This information will help us better understand your child's current situation so we can more fully address these presenting issues in a like manner.

Child's name:_____ DOB:_____/_____ Age:_____

PRIMARY PROBLEM

What is the primary reason for sending your child to Sorenson's:

What are the secondary reasons?

How long have the above listed been a problem? Do you see any underlying cause to these problems?

DEVELOPMENTAL HISTORY

PRENATAL/BIRTH HISTORY

Health of Mother: ☐ Good ☐ Fair ☐ Poor ☐ Do not know

Did the mother use any of the following during pregnancy?

☐ Alcohol ☐ Marijuana/Cocaine/Crack
☐ Cigarettes ☐ Coffee/Caffeine Drinks
☐ Prescription drugs (list):_____ _____
_____ _____
_____ _____
☐ None of the above

Any medical complications during pregnancy? ☐ Yes ☐ No

Comment:_____

Length of Pregnancy in months or weeks if known:_____

Birth Weight:_____

Were there any complications during or following birth(check all that apply)?

- ☐ Baby given oxygen
- ☐ Baby on heart monitor
- ☐ Blood transfusions (baby)
- ☐ Birth defects
- ☐ Delivery by cesarean section
- ☐ Delivery aided by instrument
- ☐ Incubator
- ☐ Other_____
- ☐ None of the above
- ☐ Problems breathing
- ☐ Problems eating/digesting
- ☐ Problems sucking
- ☐ Rashes
- ☐ Very active
- ☐ Very quiet
- ☐ Jaundice

EARLY DEVELOPMENT

Behavior	Age	Comments
Walking	_____	_____
Talking	_____	_____
Toilet Trained	_____	_____

Overall, you feel your child developed at the following rate: ☐ Slow ☐ Normal ☐ Rapid
Comments:_____

During the first three years of life, your child frequently exhibited (Check all that apply):

- ☐ Accident prone behavior
- ☐ Over-active behavior
- ☐ Restless behavior
- ☐ Distractibility
- ☐ Temper tantrums
- ☐ Problems with sleeping/walking patterns
- ☐ None of the above
- ☐ Lack of coordination
- ☐ Colic
- ☐ Withdrawn behavior
- ☐ Self-hurting behavior
- ☐ Feeding Problems
- ☐ Avoidance of cuddling
- ☐ Destructive behavior
- ☐ Unresponsive to discipline
- ☐ Extreme mood changes
- ☐ Head banging

Comments:_____

SEXUAL HISTORY

Is your child: ☐ Prepubescent ☐ Pubescent

(For Female Student):

Menses onset:_____ Menstrual history normal: ☐ Yes ☐ No

Frequency of Menstrual cycle:_____

Special Considerations:_____

I give approval for my daughter to be given birth control____ Disapproval____.

I would like to discuss the issue of birth control further with SRS Personnel____.

_____ _____
Parent/Guardian signature Date

To the best of your knowledge your child is:

sexually active:			
uses contraceptives:	☐ Yes	☐ No	☐ Unknown
history of pregnancy:	☐ Yes	☐ No	☐ Unknown
history of abortion:	☐ Yes	☐ No	☐ Unknown
fathered a child:	☐ Yes	☐ No	☐ Unknown

Comments:_____

contracted a venereal disease: ☐ Yes ☐ No ☐ Unknown

If yes, please list type, medications, and date of last treatment:_____

Do you have any concerns regarding your child's sexual development or sexual orientation?

☐ Yes ☐ No

Comments:_____

HEALTH/MEDICAL HISTORY

Sex:_____ Age:_____Height:_____Weight:_____

Primary Care Physician/Pediatrician(include address and telephone):_____

Does your child have any allergies? ☐ Yes ☐ No If yes, please specify:

_____

Are childhood immunizations up to date? ☐ Yes ☐ No ☐ Unknown ☐ Exemption

Date of last Tetanus shot:_____

I give permission for my child to have an annual flu immunization at an additional cost.

_____ _____

Parent/Guardian signature Date completed

Date of last complete Physical:_____ Date of last Dental Check up:_____

Has your child been diagnosed and/or currently being treated for any of the following?

☐ ADHD	☐ heart problems	☐ anemia	☐ HIV/AIDS
☐ asthma	☐ cancer/Leukemia	☐ cerebral Palsy	☐ diabetes
☐ ear Infections	☐ encephalitis	☐ epilepsy	☐ fever above 105 degrees
☐ hearing problems	☐ hydrocephalus	☐ lead poisoning	☐ loss of consciousness
☐ meningitis	☐ mental Retardation	☐ seizures	☐ vision problems
☐ anorexia	☐ appendicitis attack	☐ arthritis	☐ musculoskeletal condition
☐ bladder infection	☐ bleeding/clotting	☐ bronchitis	☐ bulimia
☐ chicken pox	☐ colitis	☐ concussion	☐ constipation
☐ convulsions	☐ diarrhea	☐ dislocations	☐ Eczema
☐ fainting	☐ fracture	☐ German measles	☐ hay fever
☐ hepatitis/jaundice	☐ hernia	☐ hives	☐ kidney disease
☐ measles	☐ migraine	☐ mononucleosis	☐ mumps
☐ pneumonia	☐ polio	☐ rheumatic fever	☐ scarlet fever
☐ sinusitis	☐ tonsillitis	☐ tuberculosis	☐ typhoid fever
☐ ulcer, stomach	☐ whooping cough	☐ Other_____	
☐ None of the above			

Comments (list year of occurrence for any checked):_____

List any family diseases and give a brief history:_____

How would you describe the nutritional value and balance of your child's diet:

☐ Good ☐ Fair ☐ Poor

Any diet restrictions:_____

Does your child have an eating or sleeping problem? (Check all that apply)

☐ Dieting
☐ Overeats
☐ Picky eater
☐ Recent weight gain
☐ Recent weight loss
☐ Refuses to eat
☐ Vomiting
☐ Other_____
☐ Other_____
☐ Does not want to sleep alone
☐ Bed-wetting
☐ Difficulty falling asleep
☐ Nightmares
☐ Sleeps too much
☐ Soiling
☐ Trouble staying asleep
☐ Very restless while sleeping
☐ None of the above

Has your child had any surgeries/accidents/conditions requiring hospitalization or same day surgery? ☐ Yes ☐ No

Date:_____ Conditions:_____

Is your child taking any medication (prescription, over-the-counter, or herbal)? ☐ Yes ☐ No
List medication/dosage/time and purpose:
1)_____

2)_____

3)_____

4)_____

5)_____
Are there any other medical conditions that would limit your child's participation in our program? ☐ Yes ☐ No

Comments:_____

SIGNIFICANT EVENTS

☐ Change of School
☐ Move to a new place
☐ Frightening experience for child/adolescent
☐ Loss of someone close to child/adolescent
☐ None of the above
☐ Death in family
☐ Serious illness or injury to family member/friend
☐ Divorce or separation

Comments:_____

BEHAVIORAL/HEALTH HISTORY

Has your child had prior mental health services, counseling, and/or drug/alcohol treatment? ☐ Yes ☐ No

Outpatient

Therapist/Program	Date	Effectiveness
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospital	Date	Effectiveness

Has your child (check all that apply):

- ☐ Physically harmed another individual, pet, or small animal?
- ☐ Received medication in the past for emotional, learning or behavioral problems?
- ☐ Run away from home?
- ☐ Started a fire?
- ☐ Talked about or attempted suicide?
- ☐ Threatened to physically harm anyone?
- ☐ None of the above

Comments:_____

_____

Has your child ever experienced or witnessed:

- ☐ Domestic violence ☐ Rape Sexual Assault ☐ Emotional Abuse
- ☐ Sexual Abuse ☐ Physical Abuse ☐ Other significant trauma
- ☐ None of the above

Comments:_____

_____

Has your child been previously diagnosed (by whom?):_____

PSYCHOLOGICAL TESTING

Has your child had previous psychological testing or evaluation? ☐ Yes ☐ No

If yes, then please send with Admissions Packet.

ACTIVITIES OF DAILY LIVING

Check areas of difficulty your child displays when performing daily activities:

- ☐ Adapting to changes ☐ Attending to tasks ☐ Decision making
- ☐ Following a routine ☐ Goal setting ☐ Learning
- ☐ Problem solving ☐ Performing Self Care (hygiene, grooming, bathing, etc.)
- ☐ Other_____ ☐ None of the above

Comments:_____

_____

Describe your child's activities outside of the home (hobbies, sports, volunteer activities, etc.):

_____

_____

Have your child's leisure time activities increased/decreased over the past 6 months? ☐ Yes ☐ No

Comments:_____

CULTURAL/ETHNIC/SPIRITUAL

Ethnic/Racial issues that need to be addressed:_____

Religious/Spiritual issues that need to be addressed:_____

EDUCATION

Grade in school _____ Ever repeat a grade? _____ Grades/Progress_____ On schedule to graduate w/peers?_____

Suspension_____ Expulsions_____ Truancies_____

Special education classes_____

Past and Current Attitude Toward School and Teachers_____

_____

_____

FAMILY HISTORY

List all of the people who are currently living in the household, also note any relationship problems or strengths:

Age Relationship to child Relationship with child

_____

_____

_____

_____

List all of the people who are currently not living in the household, also note any relationship problems or strengths:

Age Relationship to child Relationship with child

_____

_____

____ Mother only____ Joint Custody ____ Father only ____ Ward of the court

____Other relative–please specify_____

____Adopted: If yes, please give age of adoption and important background information:

Frequency of contact between non-custodial parent and your child:_____

Have any family members had problems with substance abuse or with mental/emotional health problems? □ Yes □ No

Comments:_____

_____

ALCOHOL AND DRUG

Describe what you know about your child's alcohol/tobacco/drug use (including substance, amount used, when started, etc.):_____

_____

_____

_____

_____

Have others expressed concerns about your child's substance abuse? □ Yes □ No

Comments:_____

_____

Has your child ever experienced any of the following with his/her substance abuse? (Check all that apply):

□ Change in peers □ Emotional problems □ Giving up previously enjoyed activities

□ Legal problems □ Memory lapse after use □ Increased frequency/quantity of use

☐ Mood swings ☐ Physical problems ☐ Relationship problems
☐ School problems ☐ Withdrawal symptoms ☐ Stealing from family/friends
☐ Work problems ☐ None of the above

LEGAL

Has your child ever had involvement with the legal system? ☐ Yes ☐ No
Does your child have any current pending legal charges? ☐ Yes ☐ No
Is your child on probation? ☐ Yes ☐ No

Probation Officer:_____ Tel(____)_____
Address_____

Has your child ever been in detention/jail? ☐ Yes ☐ No
Does your child have any gang involvement? ☐ Yes ☐ No

Comments:_____

SOCIAL SUPPORT/PEER INTERACTIONS

Describe views of social support/peer interactions/ability to make and keep friends:

STRENGTHS/ASSETS

Please list any strengths/assets that you view your child having:

_____ _____
Parent/Guardian signature Date completed

_____ _____
Parent/Guardian signature Date completed

_____ _____
Receiving clinician Date received

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT, that I/we _____the parents(s)/legal guardians ("client"), do hereby certify to Sorenson's Ranch School, that I/we are true and lawful attorney in-fact for _____,("student"), and student is my/our _____. ("son/daughter") We hereby execute this Power of Attorney for the purpose of providing custodial care, educational, group, and milieu therapy services in connection with Sorenson's Ranch School ("SRS").

Without limiting or qualifying the general Power of Attorney granted and delegated by Client to SRS in the paragraph above, Client specifically grants to SRS the following powers:

1 To provide or obtain all medical, dental, psychiatric treatment, and hospital care, and to authorize a physician to perform any and all procedures that may appear to be medically necessary for the well being of the Student, and release any results, records, or reports on said procedures to SRS medical personnel.

2. To guide and discipline the Student as deemed necessary and reasonable by SRS (but not to include physical punishment).

3. To physically restrain the Student should he/she become a danger to himself/herself or to anyone else, as deemed necessary by SRS.

4. To allow the Student to participate in all activities.

5. To search the person and personal effects of the Student at any time, and seize and confiscate any items deemed by SRS to be contraband or counterproductive to the Student's successful completion of the Program.

6. To submit for and receive disbursements from any available trust fund, insurance, or government agency the client provides information for.

This Power of Attorney shall be effective from date of arrival, beginning _____. 20_____ and ending upon the Student's completion of the Program, unless terminated by Sponsor by withdrawing the Student from the Program prior thereto.

I/We have executed this Power of Attorney on this _____day of _____, 20_____.

_____ _____

Father/Guardian Signature Mother/Guardian Signature

SORENSON'S RANCH SIGNATURE FORM

Name of student: _____
(Cross out section if you do not wish to sign)

My student has permission to attend any church of his/her choice.

_____ _____
DATE SIGNATURE

Sorenson's Ranch School has my permission to use name, photos, and audio/video/digital-recordings of my student in brochures or publicity.

_____ _____
DATE SIGNATURE

Sorenson's Ranch School has my permission to use my name for referrals to prospective parents.

_____ _____
DATE SIGNATURE

I agree that my student may be tested at any time that alcohol or drugs are suspected.

_____ _____
DATE SIGNATURE

I grant permission to staff at SRS to transport my student to and from activities.

_____ _____
DATE SIGNATURE

I grant permission for a staff to dispense medications as prescribed by a doctor to my student.

_____ _____
DATE SIGNATURE

I consent to have my student photographed for the secured Parent Services pages on the SRS website. (This is to provide parents with pictures of their student participating in activities.) I understand that my student may be part of a group picture that may be seen by other parents of students currently enrolled at Sorenson's Ranch School. I understand that without this consent, pictures of my student will NOT be posted to the Parent Services pages.

_____ _____
DATE SIGNATURE

I consent to allow my child to ride horses while at Sorenson's Ranch School and release Sorenson's Ranch School from any liability if an injury should occur during this activity.

_____ _____
DATE SIGNATURE

I consent to allow my child to participate in an annual STD education class.

_____
DATE SIGNATURE

Sorenson's Ranch School
P.O. Box 440219
Koosharem, UT 84744
(435) 638-7318
FAX: (435) 638-1113

PERMISSION TO REQUEST SCHOOL RECORDS

Name of Student _____D.O.B.:_____

Most Recent Schools attended:

School Name:_____ Phone:_____

Street Address:_____ Fax #: _____

City:_____ State: _____ Zip: _____

School Name:_____ Phone:_____

Street Address:_____ Fax #: _____

City:_____ State: _____ Zip: _____

Requested records include the following:

1. Transcripts
2. Withdrawal grades, including any uncompleted class
3. Health records
4. Immunization Records
5. Any Counseling Information
6. Special Education/Guidance records

I, _____, authorize Sorenson's Ranch School to request and
Parent/Guardian

receive these academic records.

SORENSON'S RANCH SCHOOL
INDIVIDUALIZED LEARNING PLAN

STUDENT NAME:_____

EDUCATIONAL HISTORY

Last School Attended:_____

Phone:_____ Fax:_____

Current Grade Level:_____ Age Appropriate Grade Level:_____

Date of Withdrawal:_____

Reason for Student Withdrawal:

Suspended Expelled Legal Discipline Normal

Does this student qualify for Special Education? Yes No

Strongest Subjects:_____

Weakest Subjects:_____

Comments/Past Academic Concerns:_____

_____

_____

_____

PERMISSION TO TEST

Student: _____

Sex: M F

Birth date: _____

Parent/Guardian: _____

Testing is done to ensure the proper placement of your child in the best educational setting for his/her learning capabilities.

Test to be given is WRAT4 (Reading, Mathematics, English).

This test will be administered and scored by a qualified examiner. The test will be given in the student's primary language and will be free of racial and cultural bias.

The testing process can only proceed with your permission. If you have any questions, please contact:

Tina Somers
SPED Teacher
435-638-1167

I give my permission for the testing listed above. I understand that the results of the evaluation will be kept confidential and will be reviewed with me.

_____
Parent/Guardian Signature

_____
Date

MAIL

Due to the potential harm that certain mail could cause our child or progress, we as legal guardians, (having both legal and physical custody) direct and authorize Sorenson's Ranch School and its staff to monitor all outgoing and incoming mail for _____ whose date of birth is _____/_____.
Student Name

It is understood that Sorenson's Ranch School is operating at our direction, under the authority we have as legal guardians, and as our agents in this behalf.

_____
Mother/Guardian

_____
Father/Guardian

_____
Date

CONSENT FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
TO SORENSON'S RANCH SCHOOL

I,_____, home address_____

authorize PREVIOUS TREATMENT PROVIDER,

1) _____

2) _____

to communicate with and disclose to one another the following information, regarding

_____ for the purpose of facilitating his treatment at Sorenson's Ranch School.
Name of Minor

(**initial each category that applies)*

_____ Immunization records

_____ Recent PPD test and results

_____ Last well child physical

_____ Labs

_____ STD testing

Other:_____

I understand that my medical records are protected under Federal regulations, i.e. the Health Insurance Portability Accountability Act (HIPAA) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____ One year after the consent form is signed

_____ Other _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal privacy regulation. Patient has a right to receive a copy of this form.

Dated: _____ _____
Signature of Parent/Guardian

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
INCLUDING ALCOHOL OR DRUG TREATMENT INFORMATION
CRIMINAL JUSTICE SYSTEM REFERRAL

I,_____, hereby consent to communication between

SORENSON'S RANCH SCHOOL and

_____, regarding
(Court, Probation, Parole, and/or Referring Agency)

_____.
Name Of Minor

The purpose of and need for the disclosure is to inform the criminal justice agencies listed above of my attendance and participation and progress in treatment. The extent of the information to be disclosed is my diagnosis, information about my participation or lack of participation in treatment, my cooperation with the program, prognosis, and

_____

_____

I understand that this consent will remain in effect and cannot be revoked by me until:

____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment or

____ _____
(Other time when consent can be revoked and/or expires)

I also understand that any disclosures made is bound by Part 2 of title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.

Dated: _____ _____
(Signature of parent, guardian or authorized Representative, if required)

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION INCLUDING DRUG AND ALCOHOL TREATMENT TO SORENSON'S RANCH SCHOOL

I,_____, home address _____

authorize PREVIOUS TREATMENT PROVIDER,

1)_____

2)_____

to communicate with and disclose to one another the following information, regarding

Name of Minor_____

(**initial each category that applies)*

_____ Student's name and other personal identifying information

_____ Information about my student's status as a patient, including drug and alcohol treatment

_____ Initial evaluation

_____ Assessment results and history

_____ Summary of treatment plan, progress and compliance

_____ Attendance

_____ Date of discharge and discharge status

_____ Discharge plan

_____ Other:_____

I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____ One year after the consent form is signed

_____ Other _____

Dated:_____ _____

Signature of Parent / Guardian

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION INCLUDING DRUG AND ALCOHOL TREATMENT TO WELFARE AGENCIES

I, _____, home address_____

authorize SORENSON'S RESIDENTIAL TREATMENT CENTER and

_____ and _____

(The Local/county Welfare agency and/or its designee) *(The State Welfare agency)*

to disclose to and communicate to one another the following information regarding

_____

Name Of Minor

_____ My name and other personal identifying information

_____ Information about my status as a patient, including alcohol and drug treatment

_____ Initial evaluation

_____ Date of admission

_____ Assessment results and history

_____ Summary of treatment plan; progress and compliance

_____ Attendance

_____ Date of discharge and discharge status

_____ Discharge plan

_____ Educational and training related information

_____ Other:_____

The purpose of these disclosures is to enable the recipients of the information to evaluate my eligibility or continued eligibility for public assistance and/or medical assistance benefits and to determine my readiness/ability to participate in a work program.

I understand that my 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 also understand that, except for action already taken, I may rescind this consent at any time. If I do not take back this consent, it expires automatically as follows:

_____ Discontinuance of assistance by the Social Service Agency

_____ One year after the date of the signing of the consent form

_____ Other_____

Dated: _____ _____

Signature of parent, guardian, or person authorized
To sign in lieu of client, where required

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
INCLUDING DRUG AND ALCOHOL TREATMENT
TO MANAGED CARE COMPANY AND INSURER

I, _____, home address _____,

authorize SORENSON'S RESIDENTIAL TREATMENT CENTER and my Managed

Care Company, _____ and

my primary insurer, _____

to communicate with and disclose to one another the following information regarding

_____
Name of Minor
(**initial each category that applies)*

_____ My name and other personal identifying information

_____ Information about my status as a patient, including drug and alcohol treatment

_____ Initial evaluation

_____ Date of admission

_____ Assessment results and history

_____ Summary of treatment plan, progress and compliance

_____ Attendance

_____ Date of discharge and discharge status

_____ Discharge plan

_____ Other:_____

The purpose of these disclosures is to enable the agencies listed above to evaluate my claim for insurance coverage.

I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____ The date on which my insurance claims for this course of treatment have been completely processed

_____ One year after the consent form is signed

_____ Other _____

Dated:_____ _____
Signature of Parent / Guardian

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION INCLUDING DRUG AND ALCOHOL TREATMENT FROM SORENSON'S RANCH SCHOOL

I, _____, home address _____,

authorize SORENSON'S RANCH SCHOOL, to release to:

1)_____
2)_____
to communicate with and disclose to one another the following information, regarding

_____
Name of Minor

(**initial each category that applies)*

_____ My name and other personal identifying information

_____ Information about my status as a patient, including drug and alcohol treatment

_____ Initial evaluation

_____ Assessment results and history

_____ Summary of treatment plan, progress and compliance

_____ Attendance

_____ Date of discharge and discharge status

_____ Discharge plan

_____ Other:_____

I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____ One year after the consent form is signed

_____ Other _____

Dated:_____ _____
Signature of Parent /Guardian

SORENSON'S RANCH SCHOOL
(Extracurricular Competitive Sports, including but not limited to Football, Wrestling, Basketball, Softball, Gymnastics, etc.)

RECREATIONAL ACTIVITY RELEASE OF LIABILITY, WAIVER OF CLAIMS, EXPRESS ASSUMPTION OF RISK AND INDEMNITY AGREEMENT
Please read and be certain you understand the implications of signing.
Express Assumption of Risk Associated with Recreational Activities.

I, _____ do hereby affirm and acknowledge that I have been fully informed of the inherent hazards and risks associated with the recreation program, including the use of equipment and transportation associated therewith of which I am about to engage in. Inherent hazards and risks include, but are not limited to:
1. Risk of injury from the activity and equipment utilized is significant including the potential for permanent disability and death.
2. Possible equipment failure and/or malfunction of my own or others' equipment.
3. This activity can take place outdoors and therefore includes risks associated with exposure to elements, excessive heat, hypothermia, etc.
6. Accidents or illness occurring in remote places where there limited access to medical facilities.
7. Fatigue, chill, and/or dizziness, which may diminish my/our reaction time and increase the risk of accident.
*I understand the description of these risks is not complete and that unknown or unanticipated risks may result in injury, illness, or death.
In addition, I authorize Sorenson's Ranch staff to act on my behalf in case of an emergency and agree to be responsible for all expenses incurred with any emergencies.
Please be advised that events will be held off campus and students could be participating in contact sports with students from other facilities or community. Students will be required to maintain an acceptable level in order to participate as well as follow all Sorenson's Ranch policies and procedures.

Release of Liability, Waiver of Claims and Indemnity Agreement
In consideration for being permitted to participate in the activity described above and related activities, I hereby agree, acknowledge and appreciate that:
1. I HEREBY RELEASE AND HOLD HARMLESS WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, or loss or damage to person or property, WHETHER CAUSED BY NEGLIGENCE OR OTHERWISE, the following named persons or entities, herein referred to as releasees.

SORENSON'S RANCH SCHOOL
410 North 100 East, Koosharem, Utah 84744

2. To release the releasees, their officers, directors, employees, representatives, agents, and volunteers, and vessels from liability and responsibility whatsoever and for any claims or causes of action that I, my estate, heirs, survivors, executors, or assigns may have for personal injury, property damage, or wrongful death arising from the above activities whether caused by active or passive negligence of the releasees or otherwise. By executing this document, I agree to hold the releasees harmless and indemnify them in conjunction with any injury, disability, death, or loss or damage to person or property that may occur as a result of engaging in the above activities.
3. By entering into this Agreement, I am not relying on any oral or written representation or statements made by the releasees, other than what is set forth in this Agreement.
This release shall be binding to the fullest extent permitted by law. If any provision of this release is found to be unenforceable, the remaining terms shall be enforceable.
I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, AND I FULLY UNDERSTAND ITS TERMS, AND UNDERSTAND THAT I HAVE GIVEN UP LEGAL RIGHTS BY SIGNING IT, AND I SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

FOR PARTICIPANTS OF MINORITY AGE: This is to certify that I, as Parent, Guardian, Temporary Guardian with legal responsibility for this participant, do consent and agree not only to his/her release of all Releasees, but also to release and indemnify the Releasees from any and all liabilities incident to his/her involvement in these programs for myself, my heirs, assigns, and next of kin.

S/_____ _____ _____

Signature of Parent or adult legal Guardian Name of Parent or adult legal Guardian (Please Print) Date
If participant is a Minor, and by their signature, they on my behalf release all claims that both they and I have

_____ _____
Name of Minor (Please Print) Date

P. O. Box 440219, Koosharem, Utah 84744
Phone: 435-638-7318 or 800-455-4590
Fax: 435-638-7582

CONSENT OF RELEASE TO INSURANCE PROVIDER

I, _____, request and authorize the clinical representative of Sorenson's Ranch School, Koosharem, Utah, to disclose a Copy of application, treatment plan information, individual and group therapy and counseling notes, progress notes, psychiatric assessment, and psychologist assessment, and medication assessment and application to (Name/title Organization to which disclosure is made)_____ for _____(Name of student). This disclosure is made to qualify the above patient to meet requirements of coverage and to obtain program evaluation while attending Sorenson's Ranch School.

This consent is subject to written revocation at any time except to the extent that the program that is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon the completion of documented discharge of patient.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

_____

Dated Signature of parent/guardian

(Complete ONLY if you have residential treatment insurance benefits) Please notify Accounts Receivable so they can start working on Prior Authorization.

Sorenson's Ranch School

ASSIGNMENT OF INSURANCE BENEFITS

You must pre-authorize coverage before student arrives at SRS

INSURANCE COMPANY_____

ADDRESS OF INS COMPANY_____

TELEPHONE NUMBER OF INSURANCE COMPANY_____

PREAPPROVAL NUMBER_____CASE MANAGER_____

GROUP NUMBER_____POLICY NUMBER_____

INSURED'S NAME_____INSURED'S SS #_____

INSURED'S DATE OF BIRTH _____

INSURED'S EMPLOYER_____

For the purposes of paying all or part of monies owing to SORENSON'S RANCH SCHOOL for services it has or will render to the above patient, the undersigned hereby irrevocably assigns to SORENSON'S RANCH SCHOOL any benefit payments payable for the benefit of said patient by the above insurance company or companies and all rights and interest in said policy but only to the extent necessary to pay SORENSON'S RANCH SCHOOL in full. Undersigned agrees to be liable to pay the full amount of all monies billed by SORENSON'S RANCH SCHOOL. As a result of rendering services to the above mentioned patient liability will be reduced by the amount of benefit payments received hereafter. Undersigned understands that the nature of patient's disability may be such that no benefit payments will be payable under the policy specified above. Any monies owing by the undersigned under the terms of this Agreement shall be paid in full within 30 days after billing by SORENSON'S RANCH SCHOOL, unless other arrangements have been made. In the event that collection efforts are undertaken by SORENSON'S RANCH SCHOOL to enforce any of the terms of the Agreement, all expenses associated therewith, including reasonable attorney's fees, will be paid by the undersigned.

_____ _____

DATE POLICY HOLDER AND/OR PARENT SIGNATURE

Please attach a photocopy of the student's medical insurance card. We must have this in order to file insurance claims.

INDIVIDUAL TREATMENT PLAN INPUT

STUDENT:

PARENT: DATE:

INDIVIDUAL CARE AND TREATMENT PLANS INCLUDING EDUCATION PLANS are made for each student. Social academic, emotional, physical goals are to be included. Please send your input:

1. Goal in life I desire for my student:

2. Goal upon termination at the ranch:

3. Objectives to work toward or problems of my student:

Copies of Monthly Progress Reports/Access to Student Webpage to be sent to the following:

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Students May Have Contact With the Following:

Please complete this list with the information on the people that your student is allowed to have contact with. Please understand that our phone policies and privileges apply regardless.

Name:_____Email Address:_____

Address: _____Phone: _____

City: _____State: _____Zip: _____Fax:_____

Relation to Student: _____
(parent, grandparent, guardian, caseworker, probation officer, etc.)

Students may have letters? Yes No Student may have phone calls? Yes No

Name:_____Email Address:_____

Address: _____Phone: _____

City: _____State: _____Zip: _____Fax: _____

Relation to Student: _____
(parent, grandparent, guardian, caseworker, probation officer, etc.)

Students may have letters?: Yes No Student may have phone calls? Yes No

Name: _____ Email Address: _____

Address: _____Phone: _____

City: _____State: _____Zip: _____Fax: _____

Relation to Student: _____
(parent, grandparent, guardian, caseworker, probation officer, etc.)

Students may have letters? Yes No Student may have phone calls? Yes No

Name:_____Email Address:_____

Address: _____Phone: _____

City: _____State: _____Zip: _____Fax: _____

Relation to Student: _____
(parent, grandparent, guardian, caseworker, probation officer, etc.)

Students may have letters? Yes No Student may have phone calls? Yes No

RE: Interstate Compact Agreement

Dear Parent or Guardian:

Federal Law requires that children cannot be placed into the care of an agency across state lines without the approval of the Interstate Compact Authorities in each state. This is intended to assure that children are placed into licensed, safe placements, and that the state laws in the sending and receiving states are followed. Even parent placements are regulated by this compact agreement, unless placing directly with a relative.

The following page is the Interstate Compact Placement Request. Please follow these steps when completing:

1. Complete **Section I** of the Interstate Compact Placement Request with the Identifying Data (student and parent information).

2. The "**Name of Agency Responsible for Planning for Child**" section and the "**Name of agency or Person Financially Responsible for the Child**" should both contain parent/guardian's names and address, **regardless of whether or not your child's placement is paid by a third party.**

3. Sign and date the request in **Section III** where it says "**Signature of Sending Agency or Person**."

We will forward the completed form to the appropriate state for processing.

It is imperative that these forms be completed properly. If you have any questions concerning this please, contact our office at 435-638-7318.

ICPC 100A
REV. 05/2019; EFF. 01/2020

One form per child; please type

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

TO: Amy Tafoya DCFS **FROM:**

SECTION I—IDENTIFYING DATA

Notice is given of intent to place—Name of Child:

Social Security Number:

ICWA Eligible ☐ Yes ☐ No

Title IV-E Eligible ☐ Yes ☐ No ☐ Pending

Sex:

Gender:

Date of Birth:

Ethnicity: Hispanic Origin:
☐ Yes ☐ No ☐ Unable to determine/unknown

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ Black or African American
☐ White

Name of Parent 1:

Name of Parent 2:

Name of Agency or Person Responsible for Planning for Child:

Phone:

Address:

Email Address (optional):

Name of Agency or Person Financially Responsible for Child:

Phone:

Address:

Email Address (optional):

SECTION II—PLACEMENT INFORMATION

Types of Care Requested:
☐ Public Placement ☐ Private Placement
Subsidy: ☐ IV-E ☐ Non IV-E ☐ Pending ☐ None
☐ Adoptive Home: Finalizing in: ☐ Sending State ☐ Receiving State ☐ Pending
☐ Foster Family Home
☐ Group Home Care
☐ Child-Caring Institution
☒ Residential Treatment Center
☐ Parent
☐ Institutional Care—Article VI Adjudicated Delinquent
☐ Relative (Not Parent) Relationship: _____
☐ Other: _____

Current Legal Status of Child:
☐ Sending Agency Custody/Guardianship
☒ Parent Relative Custody/Guardianship
☐ Court Jurisdiction Only
☐ Protective Supervision
☐ Parental Rights Terminated—Right to Place for Adoption
☐ Unaccompanied Refugee Minor
☐ Other: _____

Name of Person(s) or Facility Child is to be placed with: Sorenson's Ranch School

Soc. Sec # (optional):
Soc. Sec # (optional):

Address: 410 N 100 E, Koosharem, UT 84744

Phone: 435-638-7318

If placement is with an agency (e.g., adoption, public, etc.) other than a residential treatment facility (RTF), please identify the foster or adoptive resource where the child will reside.

***Name(s) of Prospective Adoptive or Foster Resource:**

Soc. Sec # (optional):
Soc. Sec # (optional):

Address:

Phone:

SECTION III—SERVICES REQUESTED

Initial Report Requested (if applicable):
☐ Adoptive Home Study
☐ Foster Home Study
☐ Parent Study
☐ Relative Home Study

Supervisory Services Requested:
☐ Request Receiving State to Arrange Supervision
☐ Another Agency Agreed to Supervise
☒ Sending Agency to Supervise
☐ Other _____

Supervisory Reports Requested:
☐ Semi-Annually
☐ Quarterly
☒ Monthly
☐ Other: _____

Name and Address of Supervising Agency in Receiving State: Sorenson's Ranch School, P.O. Box 440219, Koosharem, UT 84744

Enclosed: ☐ Child's Social History ☐ Court Order ☐ Financial/Medical Plan ☐ Other Enclosures
☐ Home Study of Placement Resource ☐ ICWA Enclosure ☐ IV-E Eligibility Documentation

Signature of Sending Agency or Person:

Date:

Signature of Sending State Compact Administrator, Deputy, or Alternate:

Date:

SECTION IV—ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC

☐ Placement may be made ☐ Placement shall not be made

Remarks:

Signature of Receiving State Compact Administrator, Deputy or Alternate:

Date

DISTRIBUTION: See 100A Instructions

SORENSON'S RESIDENTIAL TREATMENT CENTER

PLACEMENT DISRUPTION PLAN

Date:

Student:
Date of Birth:
Ward of:
Contact information:

In the event the student's treatment is disrupted before completion of their program, either at their parents/guardians' request, concerns that their mental health or behavioral issues require more extensive treatment, or for some other unforeseen circumstance, the following steps will be taken:

SCHOOL DISTRICT

1. The assigned therapist will notify the Administration of the pending discharge.
2. The assigned therapist will discuss the discharge plans with the student's parents/guardians and how they will proceed, either to help the parents/guardians find a suitable treatment alternative or to help make travel arrangements for the student to return home.
3. The Facility Director will discuss the discharge plans with the student's School District representative and how they will proceed to find a suitable treatment alternative.
4. The School District will be given 20 days to find a new placement as per the agreement.
5. The student will be informed of the arrangements that have been made at the appropriate time.

PRIVATE PLACEMENT

1. The assigned therapist will notify the Administration of the pending discharge.
2. The assigned therapist will discuss the discharge plans with the student's parents/guardians and how they will proceed, either to help the parents/guardians find a suitable treatment alternative or to help make travel arrangements for the student to return home.
3. The parents/guardians will be given two weeks to either find an alternative placement or return the student to their home.

P. O. Box 440219, Koosharem, Utah 84744
Phone: 435-638-7318 or 800-455-4590
Fax: 435-638-7582

4. The student will be informed of the arrangements that have been made at the appropriate time.
5. In the case of parents/guardians moving and refusing to inform Sorenson's Ranch School of their new address, Sorenson's will transport the student to the Child Protection Agency in their home state.
6. In the event the student has a social worker or probation officer involved in their treatment, the assigned therapist will notify them of the pending discharge and if necessary, work with the social worker or probation officer to return them to their home state.
7. In the event the student is taken into custody by local law enforcement, Sorenson's Ranch School will discuss the discharge plans with the student's parents/guardians and how they will proceed, either to help the parents/guardians find a suitable treatment alternative or to help make travel arrangements for the student to return home.
8. If the student has reached majority and is staying at Sorenson's Ranch School under a variance that has been granted and decides to leave, Sorenson's Ranch School will discuss the discharge plans with the student's parents/guardians in order to help make travel arrangements for the student to return home.

If a student leaves Sorenson's Ranch School without following this placement disruption plan, the following steps will be followed:

1. Sorenson's Ranch will notify the parents/guardians, the Office of Licensing, and the Sevier County Sheriff's Department.
2. Sorenson's Ranch will assist the authorities in locating the student.
3. When the student is located, Sorenson's Ranch will arrange transportation of the student, at the parents' expense, either back to our facility, to the student's parents/guardians, or to another treatment facility.

Sorenson's Ranch School
P.O. Box 440219
Koosharem, Utah 84744
PHONE (435) 638-7318 /FAX (435) 638-7582

Dear Parents,

Sorenson's Ranch School is able to accept **Visa, MasterCard, American Express,** or **Discover** for payment. This method of payment may be beneficial to those who earn extra credit or miles for every dollar they spend.

All credit cards are debited on or about the 25th of each month automatically for the next month. Please fill out the needed information, sign the authorization, and mail back to the address at the bottom of the letterhead. An itemized bill will be sent to you each month with all charges and credits that were applied.

If you have any questions please feel free to contact me.

Sincerely,

Mindy Talbot

CREDIT CARD AUTHORIZATION
(please print)

I _____ hereby give my permission for Sorenson's

Ranch School to debit my credit card monthly tuition and all other monthly charges for my

Child: _____.

Credit Card Number _____

Exp. Date _____ CVC code: _____

Signature _____ Date: _____

Please list the billing address EXACTLY as it appears on your credit card statement.

Address: _____

City: _____State: _____Zip: _____

Day Phone: _____Evening Phone: _____

Sorenson's Ranch School
P.O. Box 440219
Koosharem, UT 84744
PHONE (435) 638-7318/ FAX (435) 638-7582

Dear Parents,

Sorenson's Ranch School **REQUIRES** that you provide a credit/debit card account for Medical Co-Pays and the Pharmacy to use for billing. Please fill out and sign the form below and return with completed Admissions Packet. All prescriptions co-pays will be billed to this card. Medical co-pays will only be charged in the event that the service provider requires one.

If you have any questions please feel free to contact me.

Sincerely,

Mindy Talbot

CREDIT CARD AUTHORIZATION
(Please Print)

I _____ hereby give my permission for Sorenson's Ranch School Provider's

to debit my credit card Medical Co-Pays and Prescriptions monthly charges for my child: _____.

Credit Card Number _____

Exp. Date: _____ CVC code: _____

Please list the billing address EXACTLY as it appears on your credit card statement.

Address: _____ City: _____

State: _____ Zip: _____ Day Phone: _____ Evening Phone: _____

TERMS OF THE AGREEMENT:
By signing this Agreement, I agree to be financially responsible for the payment of all prescriptions, other medications, supplies, and pharmacy service fees, including but not limited to delivery and administrative fees, provided to Customer. I agree to provide the pharmacy with any and all current information regarding prescription insurance coverage or medical assistance programs under which Customer is eligible. If Customer's insurance company or medical assistance program does not pay the entire balance of an item, the balance due will be charged to this account. I agree to allow the pharmacy to retain a copy of my credit card on file. Credit card charges are processed when service is rendered. I agree to notify the pharmacy of any changes to my credit card, i.e. lost, stolen, new card numbers, expirations date changes, etc.

Print Name: _____

Signature: _____ Date: _____