CLIENT REGISTRATION

(CONTINUED)

CONSENT FOR RELEASE OF INFORMATION I hereby authorize the release of information from the following sources to Serenity Grace Farm:

Medical History

Physician_____ Phone#_____

Therapy Program(s)

Therapist_____ Phone #_____

_____ _____

_____ _____

School or Residential Facility

Facility_____ Phone#_____

Signature of Release _____Date_____

Relationship to Client_____

CONFIDENTIALITY. Serenity Grace Farm is bound by confidentiality requirements of state and federal laws; we will not disclose confidential client information without permission.

RESPONSIBILITY FOR PAYMENT. I hereby acknowledge that I am ultimately responsible for all charges applied to my account. I further acknowledge that I have read and understand the Payment Policy Notice (separate form).

Client Name_____

Name of Payor_____

Billing Address_____

City/State/Zip_____

Payor Preferred Phone #_____ **E-mail Address**_____

Signature_____ Date_____

Relationship to Client_____