



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.)
- H. Initial payment consisting of first full month of tuition plus the admission fee of \$2,500 (which covers initial clothing) must be brought with the child at time of placement.

FORMS

Parent Checklist
Application for Admission
Enrollment Contract & Exhibit "A"
Albertson's 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

SORENSEN'S RANCH SCHOOL

P. O. BOX 440219
 KOOSHAREM, UT 84744
 (435) 638-7318 FAX (435) 638-7582
 email: admissions@sorensranch.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 SECURITY #	AGE	BIRTHDATE	PLACE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
	HAIR COLOR	EYE COLOR	HEIGHT	WEIGHT		
FATHER	WAS APPLICANT ADOPTED? NO <input type="checkbox"/> YES <input type="checkbox"/>		RACE		RELIGION	
	IF YES, AT WHAT AGE		GRADE LEVEL ENTERING			
	FATHER'S FULL NAME		ADDRESS			
	TELEPHONE	BIRTHDATE	SOCIAL SECURITY #		EMAIL ADDRESS	
MOTHER	EMPLOYER <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		ADDRESS OF EMPLOYER		TELEPHONE # OF EMPLOYER	
	MOTHER'S FULL NAME		ADDRESS			
	TELEPHONE	BIRTHDATE	SOCIAL SECURITY #		EMAIL ADDRESS	
	EMPLOYER <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		ADDRESS OF EMPLOYER		TELEPHONE # OF EMPLOYER	
ARE PARENTS MARRIED <input type="checkbox"/> NO & LIVING TOGETHER <input type="checkbox"/> 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		
	ADDRESS		CITY	STATE	ZIP	
					ALLERGIES:	
					CURRENT MEDICATIONS:	
* ATTENTION MEDICAL PROVIDERS: PLEASE USE THIS ADDRESS TO SEND ALL MEDICAL BILLS TO AFTER BILLING						
MEDICAL 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 _____

ENROLLMENT CONTRACT

Enrollment Contract made by, between, and among Sorenson’s Ranch School, Inc., a corporation organized and existing under and by virtue of the laws of the State of Utah with its principal place of business at or near Koosharem, Utah (“SRS”), and the undersigned, whether one or more (“Client”), for benefit of the child or ward of Client (“student”):

Recitals

1. SRS owns and operates a facility at or near Koosharem, Utah, for the purpose of providing rehabilitation and educational services for students with special needs.
2. SRS is properly licensed by the Utah State Department of Human Services.
3. Client desires to employ SRS for purposes of providing rehabilitation and educational services to student, for the consideration, and subject to the terms contained herein.

NOW THEREFORE THIS CONTRACT

1. Authority of Client. The Client affirms that they are the legal guardian, having both legal and physical custody of _____, hereinafter known as the “student,” whose birth date is ____/____/____; and, that Client expressly desires to contract for enrollment of the student in SRS according to the terms of this agreement.
2. Enrollment Contract. Sorensens Ranch is a 12-month program. A client should expect a 12-month length of stay. However the length of stay may vary, shorter or longer than 12 months, due to the client’s ability to learn and change. Client agrees to enroll student with SRS and pay good and valuable consideration for services rendered, and SRS agrees to render rehabilitation and educational services for and on behalf of said student, all as set forth in this Contract. Client acknowledges and agrees that SRS conditional acceptance of the student is subject to the personal evaluation and screening process conducted by SRS. If the student satisfies SRS’s screening criteria, SRS shall accept the student and permit the student to complete the program. If the student fails to satisfy SRS’s screening criteria the student will be returned promptly to Client and SRS will also return the prepaid tuition fee for the client less the \$2,500 admittance fee and a deduction for all reasonable expenses incurred by SRS in behalf of the student.
3. Consideration. Client agrees to pay SRS in consideration for services to be rendered the following amounts and at the following times:
 - A. Initial enrollment fee of \$8,000.00 due in full upon enrollment. The enrollment fee shall be applied to satisfy tuition of \$5,500.00 for the first month of the enrollment term and a non-refundable admittance fee of \$2,500.00 for processing, testing and assessment of the student. The enrollment fee is due on or before the first day of admission.
 - B. Monthly tuition in the amount of \$5,500.00, due each and every month during the period of enrollment, due on or before the fifteenth of each month and each month thereafter.
 - C. Client shall be responsible to satisfy miscellaneous expenses. Payment shall be made in full by the fifteenth of each month.

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- D. Any payments more than 30 days past due may be subject to interest charges at a rate of 18%.
 - E. Students may be sent home at parents' expense when payments are more than 30 days past due.
 - F. School records will not be released until all tuition payments and miscellaneous expenses have been paid in full.
4. Individual Treatment Plan. An individual treatment plan will be formulated for student and services will be provided on a reasonable and regular basis. Services provided may include: Individual therapy with a Clinical Social Worker, Certified Social Worker, a Licensed Addiction Counselor, a Marriage Family Therapist, a Licensed Clinical Psychologist, a Licensed Clinical Social Worker, a Licensed Social Worker, an intern for a Licensed Clinical Psychologist, a Social Work Intern, a Certified School Counselor, or a combination thereof.
- A. Group Sessions. SRS will provide, and student will be required to participate in, group Sessions, as determined by SRS, which may be one or more of the following:
 - i. Life-skills Group. Counseling will be offered by certified and trained counselors in groups of approximately 12 students. Counseling sessions focus on issues of self-esteem, identity, decision-making, and communication skills. Particular topics may include stress reduction, goal setting, and values clarification.
 - ii. Prevention/Intervention Group. Group counseling sessions of approximately 12 students each, supervised by certified substance abuse counselors will be provided to address the nature of substance abuse addiction and disease, the particular properties and ramifications of various drugs, both legal and illegal, and the biological, physiological, and social consequences of controlled substance abuse.
 - iii. Support Therapy Group. Groups of various sizes will address problems resulting from sexual abuse as children, with a focus upon how this abuse impacts adolescence.
 - iv. Adoption Group. Peer group sessions will be offered for students to explore the dynamics of adoption, and to resolve issues resulting from perceived rejection or abandonment.
 - v. Anger Group. Sessions will be offered for students to learn the Anger Sequence, typical motives for anger, and the dynamics of assertiveness.
 - vi. Grief Therapy Group. For students who have lost someone significant in their life to death.
 - vii. Other groups as available.
 - B. Case Manager. Each student will have contact with an individual case manager who will serve as a role model and mentor. The caseworker will act

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as liaison between parent or guardian and student with regular communications to the parent or guardian.

- C. Milieu Therapy. Contingency-based behavioral modification, based on points and levels, with daily assigned chores and expectations, will be provided to allow the student to learn the connection between actions and consequences.
 - D. Focus will be on teaching relationship skills, anger management, and conflict resolution tools involved in communal living, to prepare the student for proper and wholesome integration into the community and society in general.
 - E. Psychiatric Visitations. Individual visits with a psychiatrist will be available for medication assessment and management.
 - F. Educational Testing. MMPI, WISC, or other testing is an additional \$125 per test.
 - G. Student Records. Records may periodically be reviewed by representatives of licensing, accreditation, law enforcement, or judicial agencies.
5. Matters Incorporated into Contract. Client acknowledges that he or she has read and understood the SRS general brochure, the parent and student manuals, the application for admission, insurance documents, health care treatment documents, family information, physician's health examination documents, confidential health history for medical examination documents, petition for release of school records, immunization records, interstate compact form for out-of-state students, permission for release of medical records, mail instructions for student, and all other documents, forms, manuals and instruction materials made available by SRS, and understands and agrees that each of said documents are incorporated into this Contract the same as though set forth fully herein. Furthermore, client covenants and agrees to cause student to conform to all obligations on the part of the student as contained in this Contract and the incorporated materials and documents.
6. Health Care Services. Sorenson's will arrange for a physical to be performed by a contracted physician within the first seven days. All costs for such medical procedures will be the responsibility of the parent/guardian. SRS shall be responsible to arrange for all necessary and reasonable health care service for student, but the cost of health care services and travel expenses to and from any health care provider, shall be assumed and satisfied in full by client, and client shall hold SRS fully harmless therefrom. Client shall reimburse SRS for any health care expenses advanced on behalf of student within 30 days after receiving written notice thereof. Client understands that SRS staff have to make numerous decisions about when to seek medical or dental help for students ranging from small to serious ailments or injuries. Staff try to make decisions by taking into consideration the added costs to the parent and the true need of the student. The Client therefore understands that SRS staff can miscalculate the timing or need of medical intervention like any parent. It is understood that SRS staff make these "judgment calls" in good faith for and in behalf of the parents. Any such "judgment calls" are subject to human error, especially since many of these judgment calls would have to be made by non-medical staff. The Client understands and agrees that SRS makes no representation and accepts no liability for the performance of any physician, dentist, clinic, or hospital to which the student is delivered for medical intervention. The Client understands these

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risks and agrees to hold harmless and release SRS and its staff from all liability associated with medical care.

7. Responsibility for Injuries, Accidents, or Illnesses. Many of the activities in which the student may participate involve some risk. There are some inherent risks of illness, including, but not limited to, illnesses that are contagious; illnesses or health risks that are common to the geographic location, illnesses connected to food services, etc. There is also risk of acts of nature, etc.
8. Policy and Procedure for Pharmacy and Medications. 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. A credit/ debit card number must be provided to Albertson's in order to pay for prescriptions and co-pays. Parents who request medications from a pharmacy other than Albertson's in Richfield, Utah, will be responsible for alerting their pharmacy concerning refills on medications. If a parent wishes to send medications from home, Sorenson's must receive these medications before the student's supply runs out. If a student's medications run out prior to medications being sent from home or other pharmacies, we will order the needed medication from Albertson's and it will be charged to the parents credit/ debit card on file.
9. Other Travel Expenses. All other travel expenses incurred by student or incurred by SRS on behalf of the student for schooling, home visits, or otherwise shall be paid and satisfied in full by client, and client shall hold SRS fully harmless there from. If SRS incurs or advances any travel expenses on behalf of student, client shall reimburse SRS within 30 days after receiving notice thereof.
10. Discipline of Student. The client consents to the discipline of their student within SRS guidelines. Interventions used are as follows:
 - a. Students will earn privileges or receive consequences based on a level system consisting of five levels. Levels will be determined by student behavior and a point system. Privileges for each level are described in the student manual. Levels three and above may leave campus for activities, levels one and two may only leave campus for work projects. On level one students will be assigned work hours that are to be completed by participating in workouts and work projects. If a student has excessive hours they may be provided the opportunity to complete their hours at an accelerated pace by receiving up to 10 hours each day they work for good behavior.
 - b. Students may be required to participate in a kinesthetic workout if they are on level one, have lost excessive points for room/chore, are on incomplete in school, or requested by their therapist or case manager for therapeutic reasons.
 - c. Students may be required to participate in hiking if they are sent out of class for any reason, disrespectful or argumentative with staff, on level one, need to de-escalate, or cool down. Students may also participate in hiking at their request.
 - d. Students may be required to participate in work projects such as feeding animals, cleaning projects, repair projects, service projects in the community, or grounds beatification projects.
 - e. Students may be required to spend time in the multipurpose room if they are a safety concern to themselves or others. Students may also spend time in the

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multipurpose room for running away, inappropriate relationships, fighting, if they need to be removed from the other students, or if their case manager/ therapist request for therapeutic reasons. They will remain in the multipurpose room until such time that the staff feel that the student is no longer a danger to themselves or others. The Client understands that all such decisions are judgment calls and are open to human or judgment error. In the multipurpose room they will have basic necessities and staff supervision. They will be required to participate in therapeutic and educational assignments as well as work projects.

- f. Students may lose the privileges of wearing regular clothing and may be required to an orange, tan, or green jumpsuit. Students may be required to wear a jumpsuit at the request of their case manager or therapist, running away, refusing to follow the program, or other violations as described in the discipline manual.
 - g. The client consents that staff may intervene physically to control and detain the student for and including, but not limited to, the following purposes: to prevent the student from jeopardizing the safety of self or others, to prevent the flight of the student into dangerous or unsupervised situations, or to prevent the destruction of property. The client consents to the use of an escort when a student needs to move from one location to another for their safety and will not do so willingly. The client consents to the use of positive control systems intervention techniques to insure a safe, positive environment for each student. SRS does not use medical or mechanical restraints.
 - h. If a student refuses to participate in behavior modification they will be directed to an unconfined area with supervision until they are willing to participate and cooperate.
11. Authorization of Search and Seizure. Client hereby consents that SRS personnel may search the person and personal effects of the student at any time. SRS is further authorized to confiscate any and all items deemed by SRS to be contraband or counterproductive to the student's successful completion of the Program. The disposition of all items confiscated by SRS shall be left to the sole discretion of SRS. Client understands and agrees that the school will not be responsible for the care or return of confiscated items.
12. Authorization for Drug Screening. Client hereby gives consent and authorizes SRS to administer to the student routine saliva or urinalysis for drugs. The Client agrees to pay for such expenses.
13. Visitation. Client may visit student on campus for two days after three months if student is on the appropriate level. During the visit one family session is offered. At six months a family visit in the surrounding area may be approved for three days if student is on the appropriate level. A family session at this time is also recommended. At nine months SRS suggests a home visit for no longer than seven days. Student must be on appropriate level for all visits. Visits are a privilege that is earned and **may be cancelled** at any time by case manager or therapist when student's level drops or loses privileges from not working appropriately on behavioral, therapeutic, or educational goals – even if travel and work arrangements have already been made. To do otherwise would be detrimental to the student's progress in the program. Do not push for exceptions.

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14. Dismissal of Student. SRS shall have the right to dismiss student at Administrations discretion for any of the following reasons:
- A. Breach of this Contract or any term, document, promise or other obligation incorporated herein.
 - B. Behavior on the part of student that seriously breaches the rules of discipline and conduct imposed and maintained from time to time by SRS.
 - C. Deviant or criminal behavior by student that significantly and adversely impacts the various programs of SRS or the effectiveness of services provided to other students.
 - D. Determined inappropriate for the program by a member of the clinical team.
15. Insurance Coverage for Tuition and Expenses.
- A. In the event that client has insurance coverage to satisfy tuition and other expenses incurred by, for, or on behalf of student, the responsibility to complete all insurance forms, process all insurance claims, and otherwise secure insurance benefits, shall be strictly and solely the responsibility of client. SRS shall not have any duty or obligation to deal directly with any insurance company, but SRS may, in its discretion, do so, from time to time.
 - B. SRS takes no responsibility for the approval or processing of insurance reimbursements, payments, or billings.
 - C. The Client agrees to maintain the fee schedule while any reimbursements or payments are being approved or processed. The responsibility for tuition is the client's and shall be paid monthly.
16. Runaway Expenses. In the event the student runs away from the program, SRS will make every reasonable effort to find the student and return the student to the program or client. An accounting of the expenses incurred by SRS in finding and returning the student will be made to the client (provided client has pre-approved such costs) who agrees to accept full responsibility for any and all such costs and expenses, and to pay the sum within seven (7) days of the client's receipt of said accounting. In the event of any complaint, demands, claims, or legal actions alleging injury, death, or any other type of damage as a result of the runaway of a student, client shall indemnify, defend and hold harmless SRS and its officers, directors, employees, and agents from any and against any and all damages, loss, or expense, including court costs and reasonable attorney's fees.
17. Detention. If your student is referred or ordered to spend time in youth detention, you will be required to pay SRS tuition and expenses plus 50% of the daily detention fees and expenses.
18. Early Termination. A 30-day notice must be given to the finance department as well as the therapist and case manager of any student being withdrawn from Sorenson's Ranch School regardless of the reason. If the student is withdrawn without notice or without fault or breach on the part of SRS, client shall be obligated to pay to SRS tuition throughout one month following such termination. The parties recognize that the payment of said amount is reasonable in light of the reliance, which SRS places upon this contract, and the time involved for SRS to replace the dismissed student.

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19. Termination. SRS reserves the right to require another placement if student has tested positive for HIV, hepatitis, or tuberculosis. This facility is not equipped to handle the mentioned diseases.
20. Health Care Insurance. Client acknowledges and agrees that it is his or her responsibility to maintain health care insurance for the benefit of student during the enrollment term. SRS shall not provide coverage of that nature, nor shall SRS be obligated to satisfy health care expenses incurred by student. Furthermore, Client agrees to procure and maintain major medical and accident insurance for the student during all times while the student is enrolled with SRS.
21. Indemnification.
- A. Client hereby indemnifies and agrees to hold SRS and its owners, officers, directors, employees, contractors, sub-contractors, consultants, and agents harmless from and against any and all claims, demands, actions, causes of action, judgments, liabilities, costs or expenses of any kind or nature whatsoever, in law, equity or otherwise, including court costs and reasonable attorney's fees, and whether presently known or unknown, suspected or unsuspected, which have existed or which may have existed or which do exist or which may arise from or relate to:
 - i. Any damages to person or property, including bodily injury or death, caused by the Client's student if he/she runs away from SRS's facilities.
 - ii. Any damages to person or property, including bodily injury or death, caused by the Client's student if such damage is caused on SRS's facilities or premises. The obligation to indemnify shall survive the termination of the Agreement.
 - B. If either party receives notice of a pending or threatened claim arising from or related to this Agreement, the party shall promptly give written notice thereof to the other party.
22. Personal Injury and Damage To Property. Client agrees to accept full responsibility for:
- A. The repair or replacement of any personal property damaged, defaced or destroyed by the students, whether owned, leased or controlled by SRS or any party.
 - B. Any personal injury to any SRS personnel, other students or third parties caused in whole or in part by the student; and to promptly reimburse SRS for any costs and expenses it may incur in connection therewith.
23. Disclaimer of Warranties. SRS makes no representation, covenant, promise, or commitment to Client or to student that the educational and rehabilitation service to be furnished by SRS to Client will cause student to progress, develop, improve, or otherwise advance in terms of social, ethical, moral, or educational respect. SRS promises to render service as stated herein, but does not warrant, express or implied, that said service will be beneficial, or deemed to be beneficial, to or for the benefit of the Client or student.
24. Personal Effects and Property. The care and maintenance of all personal property belonging to Client is the responsibility of Client and student. Client agrees to hold SRS harmless for any loss or damage to said property. It is recommended that expensive or sentimental items are left at home or are at SRS only at the sole risk of the student or

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Client. The Client agrees that SRS is not responsible or liable for items left behind on visits, leave, or when the student exits SRS.

25. Unauthorized Actions of Employees. The Client understands and agrees that SRS can only be responsible and/or liable for their employees to the degree that the employees operate within the scope of their employment and outlined job responsibilities. This does not relinquish the staff member from their individual liability for damages and/or prosecution for their actions outside of their constituted job duties or realm of employment. The Client therefore agrees to hold harmless and release SRS from all liability or damages for any actions of SRS staff or employees that act outside the training they have received or the scope of their constituted responsibilities or realm of their employment.
26. Staffing. Client understands that staff are hired not necessarily by credentials but to provide supervision and carry out the structured environment designed to benefit students at SRS.
27. Supervision. Client understands that the amount of supervision varies with each student depending on the child's current status. SRS provides a high level of supervision, but it is understood that the supervision provided, regardless of status, does not guarantee that accidents, injuries, self harm, fighting, acts of physical aggression, runaways, suicide attempts, sexual activity or use of alcohol, tobacco or other harmful substances cannot happen. These risks are present in any segment of society no matter how closely supervised or protected.
28. Termination of Enrollment on Majority. SRS is located in the State of Utah. The age of majority in Utah is age eighteen (18). Client acknowledges that the student may withdraw from SRS at any time upon student's attaining the age of eighteen, without notice to or consent of Client, and that SRS has no obligation or authority to require the student to remain enrolled. Client releases and indemnifies SRS from all claims, damages, causes of action, etc. in any manner relating to a student leaving the premises/school/program once the student reaches the age of eighteen and Client acknowledges that SRS has no obligation or duty to the Client or the student regarding the manner in which the student leaves, destination, method of travel, notification of parents or other person, etc. Client further acknowledges that SRS may terminate the enrollment of any student on or after the student's eighteenth birthday at SRS's sole discretion if SRS deems it inadvisable to keep the student enrolled in SRS and that such termination may be without prior notice to either Client or the student.
29. Protection of Community Image. The Client understands that upon leaving SRS, their child will not go to school or live within 100 miles of SRS, unless (1) permission is given in writing by SRS, (2) their child is 18 years of age, or (3) the student is living with the parents. Client agrees that failure to comply with this provision would result in the Client being responsible for paying SRS the normal monthly fee for the period of time involved.
30. Conflict of Interest. The Client understands and agrees under strict penalties of damages that they will not contract with any SRS employees or former employees for any related or even non-related services while the student is enrolled in SRS or upon discharge, or for a period of one year after the student is discharged from SRS, without specific and written permission from the Director. The Client also agrees under the same penalties that they will not allow their child to live with or reside in the home of an employee or

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former employee, upon discharge, or for a period of one year after the student is discharged from SRS, without specific and written permission from the Director.

31. Client Cooperation. Client agrees to give SRS and SRS personnel full cooperation throughout the program in order to maximize the benefits of the program for the student and client.
32. Governing Law, Venue and Succession. The laws of the State of Utah shall govern the construction and interpretation of this Contract. All money due and owing pursuant hereto by client to SRS shall be payable to SRS at SRS's place of business in Koosharem, Sevier County, Utah, and venue of any action hereunder shall be exclusively within said county and state. This agreement shall bind these parties, as well as their estates, personal representative, assignees, and successor in interest.
33. Attorney's Fees. In the event that client defaults under this Contract, by failing to pay any money when due, or by breaching any other term or provision contained herein, then client agrees to pay to SRS a reasonable attorney's fee, whether or not suit is commenced, and if commenced, whether or not prosecuted to final judgment or decree.
34. Acknowledgment/Entire Agreement. Client hereby acknowledges that client has read this agreement and that client understands and consents to all of its provisions; that this agreement constitutes the entire agreement between the parties hereto with respect to the subject matter hereof; and that no other prior agreements, promises, expectations and conditions, oral or written between the parties are incorporated herein. Client understands that during the course of enrollment the interventions, tuition and expenses, therapy, or any other aspect of the program can change without notification to the parents.
35. Binding Effect. This agreement shall be binding upon and inure to the benefit of the parties hereto, their heirs, personal representative, successors and assigns.

IN WITNESS WHEREOF,

the parties execute this Contract the ____ day of _____, 20 ____.

Father/Guardian Signature

Printed Name

Mother/Guardian Signature

Printed Name

Witnessed By Sorenson's By _____

Sorenson's Ranch School

**Lin's Pharmacy
Insurance Form
670 N. Main Street
Richfield, Utah 84701
(435) 896-9253**

Please provide all 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 Lin's at (435) 896-9253.

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: _____

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

<u>Behavior</u>	<u>Age</u>	<u>Comments</u>
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

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?

- | | | | |
|---------------------------------------------|----------------------------------------------|------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> heart problems | <input type="checkbox"/> anemia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> asthma | <input type="checkbox"/> cancer/Leukemia | <input type="checkbox"/> cerebral Palsy | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> ear Infections | <input type="checkbox"/> encephalitis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> fever above 105 degrees |
| <input type="checkbox"/> hearing problems | <input type="checkbox"/> hydrocephalus | <input type="checkbox"/> lead poisoning | <input type="checkbox"/> loss of consciousness |
| <input type="checkbox"/> meningitis | <input type="checkbox"/> mental Retardation | <input type="checkbox"/> seizures | <input type="checkbox"/> vision problems |
| <input type="checkbox"/> anorexia | <input type="checkbox"/> appendicitis attack | <input type="checkbox"/> arthritis | <input type="checkbox"/> musculoskeletal condition |
| <input type="checkbox"/> bladder infection | <input type="checkbox"/> bleeding/clotting | <input type="checkbox"/> bronchitis | <input type="checkbox"/> bulimia |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> colitis | <input type="checkbox"/> concussion | <input type="checkbox"/> constipation |
| <input type="checkbox"/> convulsions | <input type="checkbox"/> diarrhea | <input type="checkbox"/> dislocations | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> fainting | <input type="checkbox"/> fracture | <input type="checkbox"/> German measles | <input type="checkbox"/> hay fever |
| <input type="checkbox"/> hepatitis/jaundice | <input type="checkbox"/> hernia | <input type="checkbox"/> hives | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> measles | <input type="checkbox"/> migraine | <input type="checkbox"/> mononucleosis | <input type="checkbox"/> mumps |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> polio | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> scarlet fever |
| <input type="checkbox"/> sinusitis | <input type="checkbox"/> tonsillitis | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> typhoid fever |
| <input type="checkbox"/> ulcer, stomach | <input type="checkbox"/> whooping cough | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> 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)

- | | |
|---------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Dieting | <input type="checkbox"/> Does not want to sleep alone |
| <input type="checkbox"/> Overeats | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Picky eater | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Sleeps too much |
| <input type="checkbox"/> Refuses to eat | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Trouble staying asleep |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Very restless while sleeping |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> 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

- | | | |
|----------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Change of School | <input type="checkbox"/> Death in family | <input type="checkbox"/> Divorce or separation |
| <input type="checkbox"/> Move to a new place | <input type="checkbox"/> Serious illness or injury to family member/friend | |
| <input type="checkbox"/> Frightening experience for child/adolescent | | |
| <input type="checkbox"/> Loss of someone close to child/adolescent | | |
| <input type="checkbox"/> None of the above | | |

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?): _____

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 _____
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.

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

Signature of Witness

Sorenson's Ranch School
PO Box 440219
Koosharem, UT 84744
435-638-7318

PERMISSION OF RELEASE OF MEDICAL RECORDS

Attention: _____
Recent Psychiatrist/Doctor Name

Hospital

Street Address

City State Zip

Phone Number

Name Of Patient _____

Date Of Birth _____

The above named patient has been accepted into Sorenson's Residential treatment Center.
I hereby request the release of his/her records to their facility.

Please include the following:

- Current Medical Information
- Psychological History

Parent/Guardian Signature

Parent/Guardian Printed Name

Date

SORENSEN'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 NAME

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

DATE NAME

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

DATE NAME

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

DATE NAME

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

DATE NAME

I grant permission for a staff to dispense medications as prescribed by a Doctor to my Student.

DATE NAME

I consent to having my student photographed for the secured Parent Services pages on the SRS website for the purpose of providing parents with pictures of activities that their student is involved in.

DATE NAME

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 NAME

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

PERMISSION OF RELEASE OF 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.

**SORENSEN'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 Resources? Yes No

Strongest Subjects: _____

Weakest Subjects: _____

Comments/Past Academic Concerns: _____

PERMISSION TO TEST

Student: _____

Sex: M F

Birth date: _____

Parent/Guardian: _____

Reason for testing is for admittance and the proper placement of your child in the best educational setting for his/her learning style.

Test to be given is WRAT3 (Reading, Mathematics, English).

This test will be administered and scored by a certified/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
435-638-1177

I give my permission for the testing listed above. I am assured 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 CONFIDENTIAL INFORMATION
INCLUDING ALCOHOL OR DRUG TREATMENT INFORMATION
CRIMINAL JUSTICE SYSTEM REFERRAL**

I, _____, hereby consent to communication between
SORENSEN'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

SORENSEN'S RANCH SCHOOL
(Extracurricular Competitive Sports, including but not limited to Football, Wrestling, Basketball, 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 football 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 takes 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 will be participating in contact football with students from other facilities. 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 (ies) 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.

SORENSEN'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

January 1, 2007

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.

I have enclosed a copy of the Interstate Compact Placement Request. Please follow these steps when completing:

1. Complete Section I of the Interstate Compact Placement Request with the vital information.
2. Sign the request in Section III where the X indicates

After you have completed the Interstate Compact Placement Request then return it to Sorenson's. We will then forward it to the appropriate state for completion.

It is imperative that these forms be completed and returned to Sorenson's immediately.

If you have any questions concerning this please contact my office at (435) 638-1109.

Sincerely yours,

Linda Burr

INTERSTATE COMPACT PLACEMENT REQUEST

TO: (Name & Address of Compact Administrator in Receiving State) Mike Chapman, Division of Child and Family Services 120 North 200 West, Room 225 Salt Lake City, Utah 84103	FROM: (Name & Address of Compact Administrator in Sending State)
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SECTION I - IDENTIFYING INFORMATION

Notice is given of intent to place:		SEX:	DOB:	ETHNIC GROUP
NAME OF MOTHER:		NAME OF FATHER:		
NAME OF AGENCY OR PERSON RESPONSIBLE FOR PLANNING FOR CHILD			TELEPHONE NUMBER	
ADDRESS				
NAME OF AGENCY OR PERSON FINANCIALLY RESPONSIBLE FOR CHILD			TELEPHONE NUMBER	
ADDRESS				

SECTION II - PLACEMENT INFORMATION

NAME OF PERSON(S) OR FACILITY CHILD IS TO BE PLACED WITH Sorenson's Ranch School		TELEPHONE NUMBER 435-638-7318
ADDRESS P.O. Box 440219 Koosharem, Utah 84744		
TYPE OF CARE:		
<input type="checkbox"/> FOSTER FAMILY CARE	<input type="checkbox"/> PARENT	<input type="checkbox"/> ADOPTION
<input type="checkbox"/> GROUP HOME CARE	<input type="checkbox"/> RELATIVE (NON-PARENT) RELATIONSHIP: _____	<input type="checkbox"/> SUBSIDY/IV-E ASSISTANCE
<input checked="" type="checkbox"/> RESIDENTIAL TREATMENT CENTER		TO BE COMPLETED IN:
<input type="checkbox"/> CHILD CARING INSTITUTION	<input type="checkbox"/> OTHER: _____	<input type="checkbox"/> SENDING STATE
<input type="checkbox"/> INSTITUTIONAL CARE (ARTICLE VI)		<input type="checkbox"/> RECEIVING STATE
LEGAL STATUS:		
<input type="checkbox"/> SENDING AGENCY CUSTODY/GUARDIANSHIP	<input type="checkbox"/> COURT JURISDICTION ONLY	<input type="checkbox"/> UNACCOMPANIED REFUGEE MINOR
<input type="checkbox"/> PARENT RELATIVE CUSTODY/GUARDIANSHIP	<input type="checkbox"/> PARENTAL RIGHTS TERMINATED-RIGHT TO PLACE FOR ADOPTION	<input type="checkbox"/> OTHER: _____

SECTION III - SERVICES REQUESTED

INITIAL REPORT (IF APPLICABLE) <input type="checkbox"/> PARENT HOME STUDY <input type="checkbox"/> RELATIVE HOME STUDY <input type="checkbox"/> ADOPTIVE HOME STUDY <input type="checkbox"/> FOSTER HOME STUDY	SUPERVISORY SERVICES <input type="checkbox"/> REQUEST RECEIVING STATE TO ARRANGE SUPERVISION <input type="checkbox"/> ANOTHER AGENCY AGREED TO SUPERVISE <input checked="" type="checkbox"/> SENDING AGENCY TO SUPERVISE	SUPERVISORY REPORTS <input type="checkbox"/> QUARTERLY <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> UPON REQUEST <input checked="" type="checkbox"/> OTHER: <u>MONTHLY</u>
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NAME AND ADDRESS OF SUPERVISING AGENCY IN RECEIVING STATE Sorenson's Ranch School P.O. Box 440219 Koosharem, Utah 84744 435-638-7318		
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ENCLOSED:	<input type="checkbox"/> CHILD'S SOCIAL HISTORY	<input type="checkbox"/> HOME STUDY OF PLACEMENT RESOURCE	<input type="checkbox"/> COURT ORDER	<input type="checkbox"/> OTHER ENCLOSURES
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SIGNATURE OF SENDING AGENCY PERSON X	DATE SIGNED
SIGNATURE OF SENDING STATE COMPACT ADMINISTRATOR OR ALTERNATE	DATE SIGNED

SECTION IV - ACTION BY RECEIVING STATE

<input type="checkbox"/> PLACEMENT MAY BE MADE <input type="checkbox"/> PLACEMENT SHALL NOT BE MADE	REMARKS
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SIGNATURE OF RECEIVING COMPACT ADMINISTRATOR OR ALTERNATE	DATE SIGNED
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DISTRIBUTION: <input type="checkbox"/> COMPLETE SIX (6) COPIES OF THIS FORM	
<input type="checkbox"/> SENDING AGENCY RETAINS ONE (1) COPY AND FORWARDS FIVE (5) COPIES:	
<input type="checkbox"/> SENDING COMPACT ADMINISTRATOR WHO RETAINS ONE (1) COPY AND FORWARDS TO:	
<input type="checkbox"/> RECEIVING COMPACT ADMINISTRATOR WHO INDICATES ACTION (SECTION IV) AND FORWARDS ONE (1) COPY TO THE RECEIVING AGENCY AND TWO (2) COPIES TO THE SENDING COMPACT ADMINISTRATOR WITHIN THIRTY (30) DAYS.	
<input type="checkbox"/> SENDING COMPACT ADMINISTRATOR RETAINS ONE (1) COPY AND FORWARDS THE OTHER COMPLETED COPY TO THE SENDING AGENCY.	

Sorenson's Ranch School
P.O. Box 440219
Koosharem, Utah 84744
(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
(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 to debit my credit card monthly tuition and all other 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: _____