Client Information

Name ____

Address ____

Date of Birth _____________

DD/MM/Year

Health Card Number (Canadian Residents) _____________ Exp Date _____________

Financial Sponsor Information

Name ____

Address ____

Form of Payment

Certified Cheque ☐ Direct Deposit ☐ Visa ☐ Master Card ☐

Credit Card Number ____

Name on Card ____

Expiry Date _______________________ Security Code __________________________

Deposit

I ____ agree to pay Ledgehill $3,000.00 as a deposit to secure my place.

Ledgehill has dedicated both treatment resources and a physical space for you, for the term chosen below. The funds that you are paying us in advance have assured the availability of those resources. Such

funds are non-refundable in the event of voluntary departure or mandatory discharge prior to the end of the term, excepting only for medical discharge as indicated on this document.

Please check the program you prefer to attend:

☐ 30-day program ☐ 45-day program ☐ 60-day program ☐ 90-day program

I ____ agree to pay Ledgehill, The total payment of $_________________________ for the ___________ day program.

I agree and understand that the remainder of the fee is due and payable prior to admission, and that fees are not refundable, except in the case of a medical discharge initiated by Ledgehill staff. In these circumstances, a 50% refund of the daily fee will be given for each day of treatment missed.

Signature		Date	