EXHIBIT 3
DMH Policy #804.01

DEPARTMENTAL RECEIPT

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

DEPARTMENTAL RECEIPT

NO. A008801

DATE _____

CLINIC NAME _____ PROVIDER NUMBER _____

REC'D FROM _____ $ _____

_____ DOLLARS

CLIENT'S NAME _____ CASE NUMBER _____

PROFESSIONAL SERVICES RENDERED

PAYMENT SOURCE. _____

CASH _____ CHECK # _____ MONEY ORDER # _____

76 R 285 (12/85)
MH-203

DEPARTMENT COPY ~~CLIENT COPY~~

_____
Signature

PRICCOBON BUSINESS FORMS (213) 921-7719