CLIENT SERVICES LOG

Client's Name: _____ Date of Intake: _____
Address: _____ Telephone Number: _____
Mental Health Provider: _____ Phone: _____
Maximum visits per year: _____ Maximum visits per week: _____   Effective date: _____
Deductible: _____ Percent Paid of R&C: _____   Copay: _____
Sliding scale fee: _____ Payment plan: _____

DOS	NOS	Service	Fee Charged	Payment	Balance	Intl