CLIENT SERVICES LOG

Client's Name: Date of Intake:						
Address: Mental Health Provider: Maximum visits per year: Deductible: Sliding scale fee: Maximum visits per week: Percent Paid of R&C: Payment plants				Telephone Number:		
Maximu	nealth Pr	ovider:Movim	Pnone:	Phone:		
Deductible: Percent Paid of R&C:				Copay:		
Sliding s	scale fee:	I creen	Payment pl	an:	.y	
						
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