The Counseling Team International
41750 Rancho Las Palmas Dr. Ste #O-2
Rancho Mirage, CA 92270
Ph: (800)651-1021 Fax: (949)855-7575
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CLINICAL SERVICE RECEIPT

Submit one form for each session

Case Number: ______________________ **Therapist Name:** ____________________________________

Date of Session: ___________________ **Session #:** ______ **(1-6)** ***Check if this is the Final Session:*** ☐

Session Duration: ________ **(Hours)** **EMDR Session:** ☐

I ACKNOWLEDGE THE SERVICES WERE PROVIDED:

____ ____

Print Name of Employee or Family Member **Signature of client or consenting adult (client under 18)**

Narrative/ Description of Session:

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DISCHARGE -DISPOSITION SUMMARY:

If this is the Final Session, please provide a brief summary of any improvements and follow-up recommendations:

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Check one: Improved ☐ Not Improved ☐

If recommendation includes additional sessions, please submit Form # 11- Authorization to extend EAP Services