TREATMENT SERVICE

NOTIFICATION OF START OF TREATMENT

Date: __________________

Therapist: ____________________________ Supervisor: _________________________

Patient's Name: ____

Patient's Address: ____

Telephone #: (W)_________________(H) ______________(C)__________________

Date of Initial Interview: __________________ Date Treatment Began: _____________

Number of sessions per week: ______________ Fee per session: ___________________

Comments:

Signature of Therapist: ___________________________________

Signature of Supervisor: ___________________________________

SUBMIT FORM TO: WCSPP, Nancy Bobker, 260 Stuyvesant Avenue, Rye, NY 10580