Connecticut Behavioral Health Associates, P. C.

THERAPY VERIFICATION FORM

Client Name: _____ Date: _____

Date of Birth: _____ Telephone Number: _____

LICENSED PROFESSIONAL THERAPIST INFORMATION:

Name: _____ Agency: _____

License Type: _____ Contact Information: _____

TREATMENT FOCUS

Substance Addiction is the main focus of treatment	Client has treatment plan with identified goals for substance addiction recovery	Other Focus of Treatment
☐ YES ☐ NO	☐ YES ☐ NO	

ATTENDANCE AND PARTICIPATION

Scheduled Appointment Dates	Dates Attended – Please Initial
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**

SIGNATURES

Please Sign and Print Your Name

_____ _____

Client **Date**

_____ _____

Licensed Therapist **Date**

_____ _____

CBHA Suboxone Coordinator **Date**

_____ _____

CBHA Psychiatrist **Date**