HEARTSEASE THERAPY

Service Agreement

Phone: 306-900-9010
E-mail: info@heartseasetherapy.com
Website: heartseasetherapy.com
PMS: heartseasetherapy.janeapp.com

Date of Referral: _____
Month DD, YYY

Referring Provider's Information

Full Name: _____

Ministry/Agency/Organization/Practice: _____

Position Title: _____

Phone: _____ Cell: _____
XXX-XXX-XXXX XXX-XXX-XXXX

E-mail: _____

Client's Information

Full Name: _____

Physical Address: _____

Phone: _____ Cell: _____
XXX-XXX-XXXX XXX-XXX-XXXX

Date of Birth: _____ Gender, Pronouns: _____
Month DD, YYY

E-mail: _____

Reason for Referral: _____

_____

_____

_____

_____

Is the client aware of this referral? ☐ Yes ☐ No

Is the Referring Provider aware of any insurance, grant, or funding for the Client to receive counselling?

☐ Yes, and I consent to you contacting me for more information

☐ No, as far as I am aware, the Client is fully responsible for any costs associated with these services

Referrer's Signature: _____ Date: _____
Month DD, YYY

Client Initials _____ Client Initials _____ Client Initials _____ Practitioner Initials _____