VERIFICATION OF COUNSELLING SERVICES

CLIENT NAME	COMPANY/PROGRAM NAME	THERAPIST NAME

FGI Case Code	Authorization #

	DATE	UNIT OF SERVICE	CLIENT SIGNATURE	WHO ATTENDED	COUNSELLORS INITIALS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10					
11					
12					
13					
14					
15					
16					

A) THIS FORMS PROVIDES PROOF OF SERVICE FOR PAYMENT PURPOSES **ONLY** ON BEHALF OF THE CLIENT.

B) SEND DUPLICATE FOR BILLING (WHERE APPROPIATE). ORIGINAL REMAINS IN FILE.