1314 Concord Road SE
Smyrna, GA 30080
Tel: (770)438-1799
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Psychological Treatment Compliance Form

Integrated Care Program

Please complete the following form weekly.

Name of Patient:________________ DOB:__________ Date of Session:_________________

1. Is presenting issue being addressed?

2. Is progress/improvement being made?

3. In your opinion, do you feel patient is ready to return to work? If not, please explain.

Notice to counseling provider: This patient has enrolled in our Integrated Care Program which provides higher level of clinical care and weekly therapy sessions. This patient has agreed that you may notify our office, Georgia Psychiatry and Sleep, if either there is evidence of non-compliance with weekly counseling sessions or if you determine that the patient represents a threat of significant harm to self or others.

Medical Release Information: I agree for medical release to be exchanged between my ICP team providers. This includes the providers at Georgia Psychiatry and Sleep and (name of therapist:)_____________________________________.
Print Name of Therapist & Phone number

____
Therapist Signature

____
Patient's Signature

____
Date