HEALTH AND HUMAN SERVICES GROUP
23392 Madero, Suite "L"
Mission Viejo, California 92691
1-800-275-7460

SERVICE RECEIPT – DEA/ EAP

Fax this form to: (949) 855-7575 ***PLEASE TYPE OR PRINT CLEARLY***

Submit with each billing
One form for each session

Check if this is the Final Session: ☐

Case Number: _____ **Therapist Name** _____

⇨ **Date of Session:** _____ **Session #:** _____ **(1-6)** **Session Duration:** _____ **(Hours)**

I ACKNOWLEDGE THE SERVICES WERE PROVIDED:

_____ _____
Signature of Employee, or Family Member **Print Name of Employee or Family Member**

Narrative Description of Session Goal and Accomplishment: **DSM CODE:** ☐

GAF SCORE: ☐

_____
_____
_____
_____
_____
_____
_____
_____

DISCHAGE -DISPOSITION SUMMARY:

If this is the Final Session please note any improvement and follow-up recommendations:

_____
_____
_____
_____
_____

Check one: Improved ☐ Not Improved ☐ Too soon to tell ☐ **GAF SCORE** ☐
Final

PLEASE MAKE COPIES AS NEEDED -Form #3