

# Therapist Verification Form

Name:

Phone Number:

License Type & License Number:

Practice Name:

Practice Phone Number & Address:

Email Address:

Licensure State: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_

Date: \_\_\_\_\_

By signing this form, you agree to a rate of \$90 per session, which may be applied to a client for up to two sessions per year. You also agree that telehealth or in-person services will be completed before submitting an invoice to [lhandy@dlhandyfoundation.org](mailto:lhandy@dlhandyfoundation.org).

Invoices must be submitted within 60 days of the date services are rendered. Any invoices submitted after 60 days will not be eligible for reimbursement and will become the financial responsibility of the client, at the therapist's discretion.