



14440 Cherry Lane Court, Suite 208  
Laurel, Maryland 20707  
Phone: 301-604-1458 | Fax: 301-604-1459

Dear Provider:

All Innovative Therapeutic Services, Corp. (ITS) clients who are receiving psychiatric care/medication management are required to attend psychotherapy with an internal or external provider.

We are requesting confirmation from you regarding a mutual client to continue psychiatric services.

Please complete the fields listed below and return it to us within **7** business days.

*Thank you in advance for your time and cooperation.*

**Client Name:** \_\_\_\_\_

**Client Date of Birth:** \_\_\_\_\_

**Client Diagnosis:** \_\_\_\_\_

**Duration Client Has Received Services:** \_\_\_\_\_ Year(s) \_\_\_\_\_ Month(s)

**Type of Service (Please check all that apply):**

- Individual Therapy
- Family Therapy
- Group Therapy
- Marriage Counseling

**Frequency:**

- Weekly
- Bi-Weekly
- Monthly
- Other: \_\_\_\_\_

Provider Signature & Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

Provider E-mail Address: \_\_\_\_\_