SEATTLE PSYCHOANALYTIC SOCIETY AND INSTITUTE

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SPSI PSYCHOANALYTIC REFERRAL SERVICE INFORMATION FORM

Please include a copy of your malpractice insurance coverage

Name: _____ Phone: _____

Address: _____

Date: _____

I am a APPP/CPP/CAPP/PPP graduate: _____

I have completed one year of the APP or CPP Program: _____

I am a Clinical Associate: _____ I am a graduate analyst: _____

I am available for **psychotherapy referrals**: Yes _____ No _____

My fee range is _____

I am available for **psychoanalytic referrals** Yes _____ No _____

My fee range is _____

I accept the following insurance plans_____

_____

If you have a **particular field of interest**, please describe: _____

_____

If there are certain **referrals you would not accept**, please describe: _____

_____

Are you willing to see **patients requiring medication** management? Yes _____ No _____