

SPSI Psychoanalytic Referral Service Information Form

I would like to be included in SPSI's Psychoanalytic Referral Service.

If so, please send a copy of your malpractice insurance coverage and complete the form below.

Name and Degree(s):

Work Address:

Work Phone:

Work Email:

I have completed one year of SPSI's Psychoanalytic Psychotherapy Program.

I am an APPP / CPP / CAPP / PPP graduate.

I am a Clinical Associate. I am a graduate analyst.

I am available for **psychotherapy** referrals. My fee range is _____ to _____

I am available for **psychoanalytic** referrals. My fee range is _____ to _____

I offer sliding scale rates.

I accept the following insurance plans:

My particular field(s) of interest are: (optional)

These are certain referrals I would not accept: (optional)

I am willing to see patients requiring medication management.