USE THIS FORM ONLY FOR SERVICE VERIFICATION REQUESTS

CONFIDENTIAL FAX

DATE: _____

Send to:
Dr. Paula Miceli, C. Psych,
Psychologist

Office Location: TS Medical Centre, 692 Euclid Avenue, Toronto, ON

Phone Number: (416) 275-3735

Fax Number: (416) 901-7217

From: _____

_____

Office Location: _____

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Phone Number: _____

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CLIENT NAME: _____ DATE OF BIRTH: _____

INDICATE THE DATES OF SERVICE AND OTHER SERVICE-RELATED INFORMATION (DURATION, COST) THAT REQUIRES CONFIRMATION IN THE TABLE BELOW. A DOCTOR'S SIGNATURE IN THE VERIFICATION COLUMN IS AN ATTESTATION OF ALL SERVICE DETAILS NOTED IN THE SAME ROW. ANY ITEMS THAT CANNOT BE VERIFIED WILL BE SPECIFIED.

SERVICE DATE	LENGTH	COST	VERIFICATION

COMMENTS:

Dr. Paula Miceli, C. Psych,
Registered Psychologist