Psychotherapy History

Kindly complete this form, in this format, in its entirety. This format is necessary for insurance prior authorization. Without this format, this request cannot be accepted. Reconciliation notes from EHRs are not acceptable for prior authorizations. Supplemental letters may also be submitted, however not as a replacement to this form and format.

Patient Name: _____ DOB: _____ Phone:_____

Current Diagnosis: _____ Start Date of Current Episode: _____

Psychotherapy History:

Type of Therapy *ex. CBT*	**Duration & Frequency** *12 weeks, once weekly*	**Start Date** *03/20/2021*	**End Date** *09/20/2021*	**Rating Scale, Start/End Score** *Hamilton Depression Scale (30/12)*

For any discontinued, not completed, therapy above, please explain the reason for discontinuation

_____ _____

Psychotherapy Provider Name and Office (printed) **Signature**:

_____ _____ _____

Date **Phone** **Email**

Mood Institute
Advancing Psychiatry through Interventions

******Please send completed form records@depressionmd.com or our fax number is 877-325-2241******