Client Provider Change Request Form

Purpose: This form is used by clients who wish to request a transition from their current clinician/provider to a different provider within INcompass Healthcare. Please complete this form in its entirety. Once submitted, this request will be reviewed by the supervisor of your current provider to determine availability and clinical appropriateness.

Please Note: *Submission of this form does not guarantee an immediate transfer. Changes are subject to provider caseload capacity and clinical alignment.*

Client Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Date of Request: _____

Current Provider Name: _____

Requested Provider (if known): _____

Have you discussed your concerns with your current provider? ☐ Yes ☐ No

Reason for Requesting a Change:

(Please check all that apply)

☐ Scheduling/Availability conflicts

☐ Preference for different appointment times (e.g., evenings, weekends)

☐ Preference for a different service delivery mode (e.g., Telehealth vs. In-person)

☐ Location preference

☐ Lack of perceived clinical progress or feeling "stuck" in treatment

☐ Preference for a different clinical approach (e.g., CBT, DBT, EMDR, etc.)

☐ Seeking a provider with a specific specialty (e.g., Trauma, Substance Use, Child/Adolescent)

☐ Disagreement regarding treatment goals or the current treatment plan

☐ Communication style or personality mismatch

☐ Lack of therapeutic rapport/trust

☐ Preference regarding provider gender or age

☐ Preference for a provider with specific cultural or linguistic competencies

☐ Feeling misunderstood or judged during session

☐ Other: _____

Detailed Explanation: *Please provide a detailed explanation regarding your request to switch providers. This information helps the supervisor ensure that your next provider is the best clinical match for your needs.*

_____

_____

_____

_____

_____

_____

To ensure the best match, please describe what you are looking for in a new provider (e.g., specific expertise in trauma, anxiety, a more directive approach, etc.):

_____

_____

_____

_____

Acknowledgment

I understand that this request will be reviewed by a supervisor and that a change in provider is subject to availability. I understand that my current treatment plan will remain in effect until a transition is formally approved and coordinated.

Client Signature: _____ **Date:** _____

(Parent/Guardian signature if client is a minor)

INTERNAL USE ONLY

(To be completed by Supervisor/Administration)

Reviewing Supervisor: _____ **Date Received:** _____

Decision:

☐ **Approved** – New Provider Name: _____ **Appt Date:** _____

☐ **Denied** – Reason: _____

Supervisor Signature: _____ **Date:** _____

Client Notified On: _____ **Method:** ☐ Phone ☐ Email ☐ Portal

New Provider Notified On: _____ **Previous Provider Notified On:** _____