Mental Health Treatment Provider Form

Note to Patient/Client:

This form must be filled out by the mental health treatment provider(s) who are providing or have provided the patient/client with remedial treatment. If the patient/client is asking for compensation for payments to more than one mental health treatment provider, please make copies of this form and have it filled out by each of them.

Note to Mental Health Providers:

Your patient/client wishes to file a claim in the *United States v. Farid Fata* claims process. He or she cannot seek reimbursement for costs related to the remedial treatment you are currently providing or have already provided unless you complete this form. Thank you for taking the time to assist this patient/client. If you or your office have any questions about this form, please call 1-877-202-3282 for assistance.

Instructions

1. This Mental Health Treatment Provider Form must be completed by the patient's/client's mental health provider.
2. If additional space is needed to complete any section of this form, please attach additional pages and include the patient's/client's name at the top of each additional page.

Section 1: General Information

Patient/Client First Name ______________ MI ___ Last Name ______________

Section 2: Mental Health Condition(s)

I have treated/am treating the patient/client named above for the following condition(s):

____

____

____

____

____

Section 3: Likelihood that Farid Fata Caused the Condition(s)

Do you believe that it is possible, probable, or definite that the condition(s) for which you are treating the patient/client was/were attributable in significant part to Farid Fata? If your belief aligns with any of those three levels of likeliness, please check "yes" below. If not, please check "no."

☐ Yes, I believe that it is possible, probable, or definite that the condition(s) for which I was/am treating this patient/client was/were attributable in significant part to Farid Fata.

☐ No, I do not believe that it is possible, probable, or definite that the condition(s) for which I was/am treating this patient/client was/were attributable in significant part to Farid Fata.

If your answer is "yes" to some of the conditions listed in Section 2, above, and "no" to others, please indicate by writing "yes" or "no" in Section 2 next to each condition.

Section 4: Treatments

Please list the current and/or past treatments and/or orders provided to this patient/client to treat the condition(s) that were possibly, probably, or definitely attributable in significant part to Farid Fata.

These “treatments” may include:

- Both **past** and **current** treatments
- Examples of treatments may include (but are not limited to): therapy sessions and prescription medications.

Section 5: Certification of Accuracy of Information

I certify that in my professional judgment, the patient/client identified above had, or continues to have, mental and/or emotional impairment(s) that possibly, probably, or definitely was/were attributable in significant part to treatment provided by Farid Fata. I understand that, by signing this document, I am declaring the information on this form to be true and accurate. I further understand that the United States is relying upon the information contained in this form to make a decision about the claims for reimbursement submitted by the patient/client to the United States District Court. I am legally authorized to practice in the state identified below, and I have provided my professional license number below.

Signature of Mental Health Provider

Date: __ __ – __ __ – __ __ __ __
MM DD YYYY

Mental Health Provider First Name

MI

Last Name

Mental Health Provider Address

City

State

ZIP Code

Mental Health Provider Primary Phone

Mental Health Provider Fax

Mental Health Provider Email Address

State Where Legally Authorized to Practice

Professional License Number

NPI Number (if applicable)

Type of Provider (for example, psychiatrist, psychologist, therapist, licensed social worker, etc.)