SPC Counseling Center Request for Change of Provider Form

To request a change in your current provider, complete Sections 1 and 2 of this form and submit the form in person to the administrative staff, or via e-mail to the Program Director at SPCDirector@didihirsch.org. Every effort will be made to accommodate your request. Someone will reach out to discuss this request with you within 5 business days.

Section 1: Current Provider Information

Date Requested: Program of Service Location: ☐ Olympic ☐ Orange County

Name of Current Provider:

Section 2: Client Information

Client Name: Date of Birth:

Address: City: State: Zip Code:

Phone:

Please select the reason(s) for request a change:

☐ Appointment Scheduling ☐ Treatment Concerns ☐ Uncomfortable

☐ Language ☐ Lack of Assistance ☐ Insensitive/Unsympathetic

☐ Age (too old/too young) ☐ Gender ☐ Unprofessional

☐ Treating family member ☐ Cultural reasons ☐ Not a good match

☐ Do not want to give a reason

☐ Other (optional):

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

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If yes, please describe what you have done to try to resolve the problem:

I understand that I will be contacted about this request within 5 working days. I prefer to be contacted by:

☐ Mail ☐ Telephone ☐ Email:

If request is made on behalf of a minor or dependent adult you are the:

☐ Parent ☐ Guardian ☐ Conservator

Name of Person making request:

Section 3: Receipt of Change of Provider Request ***Internal Use Only***

Received by: Date: Copy given: ☐ Yes ☐ No

Section 4: AUTHORIZED USE ONLY

Was Request Granted: ☐ Yes ☐ No

If no, reason for rejection:

If yes, new assigned practitioners name:

Notified Client by: ☐ Mail ☐ Phone ☐ Email

Client Contacted on: By:

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