



P.O. Box 241621
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www.privatepractice.org

Membership Form

Therapist Name _____

Practice / Group Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Fax Number _____ E-mail _____

State Senator _____ District # _____

How Did You Hear About APPT? _____

MEMBERSHIP TYPE:

- Traditional (private practice therapist) – fee is equal to what you charge for one hour of therapy
- Associate (agency therapist, retired therapist, non-practicing therapist) – \$50/year
- Student (\$25/year)

PROFESSIONAL AFFILIATION:

- Counseling
- Psychology
- Psychiatry
- Social Work
- Marriage & Family Therapy
- Other _____

MY PRACTICE IS:

- Full-Time
- Part-Time
- Not in Private Practice at Present

WHICH ISSUES ARE MOST IMPORTANT TO YOU?

- Clinical Issues
- Client Management
- Marketing/Branding
- Pricing/Billing
- Technology Issues
- Other _____

DUES (See Membership Type, above) \$ _____

Voluntary Donation for Legislative Action \$ _____

TOTAL \$ _____

Please enclose your check, made payable to APPT
Mail to: APPT • PO Box 241621 • Omaha, NE 68124-5621

OR PAY BY: Visa Mastercard (name on credit card statement will be: Image Building Communications)

Name on Card _____

Card Number _____ Exp. Date _____

Card Billing Address _____ Zip Code _____

Signature _____

FOR OFFICE USE ONLY: Date Received _____ Check # _____ Added to E-List _____ Added to Directory _____

Notified SB _____ Sent E-mail _____ Traditional Members ONLY: Added to Evite (Peer Consult) _____