NEW HORIZONS COUNSELING SERVICES, INC

PATIENT REFERRAL INFORMATION (PRI)

Today's Date:_____

LEGAL Name: _____ Nickname:_____

DOB: ____/_____/_____ Age_____ Gender: _____Social Security Number: _____ -_____ -_____

Address:_____
Street City State Zip

Main Contact #:_____

Email: _____

☐ NO INSURANCE FEES: Intake: _____Session: _____PE_____MED CK_____

Primary Insurance: ☐ Physical Card Front/Back Scanned

☐ SECONDARY
(Found on pg 2)

☐ DEDUCTIBLE:_____ COPAY:_____ Out of Pocket_____

Intake_____Session:_____PE:_____MEDCK:_____

Insurance Company: _____

ID #_____ Group #_____

Member Name: _____EFF DATE:_____

Chief Symptom/Issue/Situation: _____

_____

Check ALL that Apply: ☐ Therapy ☐ Medication Management

Availability: _____
(Be specific: ASK the client all possible times, including days off through the week or lunch)

Referral Source: _____
(Referral Name & Relationship to client)

If applicable:
PCP / Practice Name: _____

Mental Health Provider/Practice Name:_____

School: _____

DAST: _____ AUDIT: _____DX: (ICD-10) _____ _____ _____ _____

Assign to_____

☐ Demographic Complete ALL sections

DATE TIME INITIALS for all information

Secondary Insurance:

Insurance Company:_____

ID #_____ Group #_____

Member Name: _____EFF DATE:_____

DATE TIME for all information with INITIALS for each entry

NOTES:_____