Referral for Counselling

The Door of Hope Counselling Clinic would like to thank the person and/or agency that referred you to our Clinic. If applicable, we also would like to invoice the person and/or organization for the full rate or sliding scale rate for the counselling session(s) fees. Therefore, with your permission, could you please complete the information below that is applicable to you. Thank you.

Client Name: _____

Referred By: Name: _____

Church or Organization: (if applicable) _____

Address of Referral: _____

Phone of Referral: May we leave a message: _____ Yes _____ No

Email of Referral: _____

Please choose one of the following fee options:

_____ 1. Client will pay his/her own counselling fees at the full rate or sliding scale.

_____ 2. Referral source will pay for _____% of the **full rate** and the client will pay the remainder to a maximum of _____ sessions.

_____ 3. Referral source will pay for _____% of the **sliding scale rate** and the client will pay the remainder to a maximum of _____ sessions.

The client is responsible to pay any and all unpaid amount if the full or partial payment from the third party is not received within thirty (30) days from the date of issue of the invoice. After thirty (30) days there will be a late payment fee charge of 2% per month on the unpaid balance.

Please invoice _____ (referral source) as indicated above.
Name of Church or Organization

_____ _____ _____

Referral Source Signature | Referral Signee (please print) | Date