**Referral Form**

Date of Referral: Click here to enter text. Date of 1st Appointment: Click here to enter text.

Client (1) Name: Click here to enter text. DOB:Click here to enter text. AGE: Click here to enter text.

Address: Click here to enter text.

Email Address:Click here to enter text. Phone#:Click here to enter text.

Okay to leave messages? YES [ ]  NO [ ]  Best time to contact? Click here to enter text.

Client’s Marital Status: [ ]  Single [ ]  Married [ ]  Partnership [ ]  Divorced [ ]  Widowed

Client (Partner): Click here to enter text. DOB: Click here to enter text. AGE: Click here to enter text.

Parent/Guardian (1): Click here to enter text. Parent/Guardian (2): Click here to enter text.

Address: Click here to enter text.

Telephone Numbers: P (1) Cell: Click here to enter text. P (2) Cell: Click here to enter text.

 P (1) Other: Click here to enter text. P (2) Other: Click here to enter text.

Okay to leave messages? YES [ ]  NO [ ]  Best time to contact? Click here to enter text.

Is the counseling for:

[ ]  Child [ ]  Adolescent [ ] Adult [ ]  Family [ ] Couple [ ] Group Therapy

Presenting Concern:

|  |  |  |
| --- | --- | --- |
|[ ]  Abuse/Type: |[ ]  ADHD/ADD |[ ]  Adjustment Issues |
|[ ]  Addiction/Type: |[ ]  Alcohol/Substance use/abuse |[ ]  Anger Management |
|[ ]  Anxiety |[ ]  Bipolar |[ ]  Chronic Illness/Pain Mgmt |
|[ ]  Court Ordered |[ ]  Cutting/Mutilation |[ ]  Death/Dying issues |
|[ ]  Depression |[ ]  Divorce/Separation Issues |[ ]  Domestic Violence |
|[ ]  Eating Disorder |[ ]  Grief/Loss |[ ]  Infidelity |
|[ ]  Life Transitions |[ ]  Men Issues |[ ]  Parenting |
|[ ]  Relationship Issues |[ ]  Self-Esteem/Self-Worth |[ ]  Stress Management |
|[ ]  Suicide Thoughts/Feelings |[ ]  Trauma/PTSD |[ ]  Woman’s Issues |
|[ ]  Gender Identity |[ ]  GBLTQ  |[ ]  Deaf/Hard of Hearing |
|[ ]  Transgendered |[ ]  School Issues |[ ]  Behavioral Problems |

Explain: Click here to enter text.

In the event of an emergency, who can we contact?

Emergency Contact: Click here to enter text. Relationship: Click here to enter text.

Telephone Numbers: Cell: Click here to enter text. (2) Cell: Click here to enter text.

Do you prefer working with a: \_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ No Preference

Is this a direct referral? [ ]  Yes [ ]  No

How did the client hear about Serenity-BHS? Click here to enter text.

**BILLING INFORMATION**

Primary Identified Client: Click here to enter text.

Is the client Private Pay or using Health Insurance? [ ]  Private Pay [ ]  Health Insurance [ ] EAP

**RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):**

Person responsible for payment: Click here to enter text.DOB: Click here to enter text.

Social Security: Click here to enter text.

Address: Click here to enter text.

Phone Number:Click here to enter text. Relationship to client? Click here to enter text.

Insurance Company:Click here to enter text. Phone Number: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: Click here to enter text.ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Pay? Click here to enter text. Deductible? Click here to enter text.

 #Sessions allowable: Click here to enter text. Rate: Click here to enter text.

If Private Pay, how much per session? Diagnosis Assessment: $Click here to enter text.

Individual Sessions: $Click here to enter text.

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly to Serenity Behavioral Health Services. I understand that I am responsible for paying my deductible or co-pay (where applicable). I agree to pay the cost of each session.

I authorize Serenity-BHS to release information to their billing company for the purpose of billings.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_