**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_