Patient Referral

Referring Doctor Information

Date______________________ Physician's Office____

Referring Physician____

Referring Physician Office Number _______________________Fax Number______________________

Patient Information

First Name ____________________Middle Initial_____Last Name________________________________

Address (No PO Boxes)____

City_________________________________State______________________________Zip____________

County____________________ Date of Birth___________________________ Age__________________

Marital Status____

Home Phone___________________________ Work/Cell Phone________________________________

Legal Guardian/Relationship____

Concerns Requiring Counseling____

Insurance Information

Is the Insured the ❑ Client ❑ Spouse/Partner ❑ Child

Insurance Company____

Name of Insured_____________________________Insured's D.O.B_______________________________

Insured's Policy #_______________________________Insured's Group #:________________________

Please Note

- We accept most private insurances and Medicaid with the following exceptions: Blue Local, Blue Value, Medicare, Partners, and VAYA
- We do have a team of interns that are accepting new clients on a pro-bono basis.