



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 _____

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, Medicare and VAYA
- From time to time, we have a team of interns that are accepting new clients on a pro-bono basis. If available, this may be offered by our office to some clients that otherwise could not afford services.