**Contact/Referral Form**

**Date of Contact: \_\_\_\_\_\_\_\_\_\_\_\_ Self-Pay or Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Member ID #: (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Client’s Information:** |
| Name:  | Gender: Male or Female | DOB/Age: |
| Street Address: | City/State: | Zip Code: |
| Telephone Number: | Email Address: |
| **If Client is a Minor complete the following:** |
| Parent/Guardian Name: | Telephone Number: |
| Relationship to Client: | Email Address: |
| **Referral Section:** |
| Referral Source: |
| Referral Type: Self-Referral Relative Agency Referral  |
| Name of Person Making referral: |
| Agency: | Telephone Number: |
| Email: | Fax Number: |
| **Service(s) Requested:** |
| Individual therapy Family Therapy Test Anxiety Services LMSW/LCSW Licensure Prep Speaking Engagement |
| **Payor Source:** |
| **What will be your payor source?:** Primary Insurance: BCBS, United Healthcare, Aetna, Cigna, Oxford Health, Oscar Health, AmeriGroup, Self-Pay **Do you have a secondary insurance?**  No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client was reminded to bring insurance card to consultation or upload card to Simple Practice**  |
| **Presenting Issues/Purpose of Contact:** |
|  |
| \*\*\*\*\*\* Office Use Only\*\*\*\*\*\* |
| **Client Consultation:** |
| No, Refer Out [ ]  Yes, Date/Time: Method: Telehealth or Face to Face |