**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 | | | |