

# Serenity Helping Hands Therapy Center, LLC

## REFERRAL FORM

PATIENT'S NAME \_\_\_\_\_ Today's Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Marital Status: S \_\_\_\_ M \_\_\_\_ D \_\_\_\_ W \_\_\_\_ ETHNICITY/ RACE: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Email Address: \_\_\_\_\_

Mobile phone number: \_\_\_\_\_

Mobile phone messages: Okay voicemail \_\_\_\_ Okay other person \_\_\_\_ No messages \_\_\_\_

Home phone number: \_\_\_\_\_

Home phone messages: Okay voicemail \_\_\_\_ Okay other person \_\_\_\_ No messages \_\_\_\_

Alternate phone number: \_\_\_\_\_

Alternate phone messages: Okay voicemail \_\_\_\_ Okay other person \_\_\_\_ No messages \_\_\_\_

May I send statements or other information to your home? Yes \_\_ No \_\_\_\_

Reason for appointment (CHECK ALL THAT APPLY):

- |                                              |                                                    |
|----------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> INDIVIDUAL THERAPY  | <input type="checkbox"/> FAMILY THERAPY            |
| <input type="checkbox"/> GROUP THERAPY       | <input type="checkbox"/> PARENT SUPPORT            |
| <input type="checkbox"/> LIFE COACH          | <input type="checkbox"/> ASSESSMENTS/ OBSERVATIONS |
| <input type="checkbox"/> MARRIAGE COUNSELING | <input type="checkbox"/> OTHER: _____              |

BRIEF DESCRIPTION OF PROBLEM (attach a separate sheet if necessary. Please email and bring to your session medical & behavioral information, court reports, social summary, previous evaluations, etc.)

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How were you referred? \_\_\_\_\_

May we thank them? Y\_\_ N \_\_\_\_

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## SPOUSE /SIGNIFICANT OTHER / OTHER PARENT INFORMATION:

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Contact Number: \_\_\_\_\_

## INSURANCE INFORMATION – PRIMARY INSURANCE – PLEASE PROVIDE CARD FOR COPY PURPOSES

Insured Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Employer \_\_\_\_\_

Group # \_\_\_\_\_

## INSURANCE INFORMATION – SECONDARY INSURANCE– PLEASE PROVIDE CARD FOR COPY PURPOSES

Insured Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Employer \_\_\_\_\_

Group # \_\_\_\_\_

## IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY, OTHER THAN FAMILY?

Name \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**OFFICE USE ONLY:** Authorization Number \_\_\_\_\_ Number of Authorized Visits \_\_\_\_\_