School-Based Therapy Intake/Referral Form

VEEMAH
Wellness and Consulting in Brooklyn Center, MN

DATE OF INTAKE/REFERRAL

Date:_____ | School Location:_____

STUDENT INFORMATION

Student Name:_____ Date of Birth: _____Grade Level:_____

Legal Gender: _____ Address:_____

Student Race/Nationality:_____

We ask to ensure we provide the best care & support based on the clients lived experiences and cultural identity.

Parent/Guardian Name (1): _____ Phone: _____

Parent/Guardian Name (2):_____Phone: _____

Best Email(s) for Required Forms: _____

_____

Emergency Contact For Student (Name, Relationship and Number)

_____

Contact Details of Person Making Referral For Student (if you are not student guardian):

PRIMARY FUNDING SOURCE

Student insurance information is required, as school-based therapy is billed per appointment like other healthcare services. Please check with your insurance company for co-pay, deductible, or other cost for therapy.

Policyholder's date of birth is needed to verify insurance. If on a parent's plan, please provide parent name and date of birth.

Policy Holder Name: _____ DOB:_____

Insurance Name:_____ Policy ID #_____

Group #_____PMI (*if applicable*) _____

If the student has more than one insurance plan, please list additional plan(s) below. We are required to verify all coverages.

Policy Holder Name: _____ DOB:_____

Insurance Name:_____ Policy ID #_____

Group #_____PMI (*if applicable*) _____

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7070 BROOKLYN BLVD, BROOKLYN CENTER, MN 55429

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(OFFICE ONLY) **NAME OF SCHOOL THERAPIST**