DIVERSE ASSESSMENTS & TREATMENT, LLC

TODD M. SIGLER, PSYD, LP, NCC

IMPORTANT

DR. SIGLER ONLY SEES INDIVIDUALS AGES *6-YEARS-0-MONTHS TO 16-YEARS-11-MONTHS* OLD WHO ARE 1) NONVERBAL, &/OR 2) MINIMALLY VERBAL, &/OR 3) ENGLISH LANGUAGE LEARNER (ELL).

REASON FOR THE REFERRAL FOR PSYCHOLOGICAL SERVICES?

☒	*SERVICE REQUESTED*	*EXAMPLES*	*COVERED BY INSURANCE?*
☐	TREATMENT &/OR SERVICE PLANNING	Rule 185, County based services, Rule 79, CADI, DD, ASD, etc.	***YES***
☐	TO ASSESSMENT AN ATTENTIONAL PROBLEMS	ADHD, Dementia, Neurocognitive Disorder	***TBD***
☐	APPLY FOR OR APPEAL A SOCIAL SECURITY DISABILITY	Social Security Hearing/Appeal	***NOT COVERED***
☐	HARDSHIP/BURDEN FOR DEPORTATION PROCEEDING	USCIS Proceeding	***NOT COVERED***

PATIENT CONTACT INFORMATION

FIRST NAME:_____ MIDDLE NAME: _____ LAST NAME: _____

GENDER: _____ DATE OF BIRTH: _____ PRIMARY PHONE #: _____

EMAIL: _____ RACE/ETHNICITY: _____ LANGUAGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WHO SHOULD I CONTACT TO SCHEDULE?

NAME: _____ RELATIONSHIP: _____

EMAIL→ _____ PHONE: _____ CELL ☐ WORK ☐ HOME ☐

REFERRAL AGENT INFORMATION

REFERRING AGENT (NAME/AGENCY): _____

ADDRESS: _____

FAX: _____ PHONE: _____ EMAIL: _____

BACKGROUND AND MEDICAL INFORMATION

CURRENT DIAGNOSES: _____ ☐ (OR ATTACH RECORDS)

CURRENT MEDICATIONS: _____ ☐ (OR ATTACH RECORDS)

PRIMARY CARE PROVIDER: _____ ☐ (OR ATTACH RECORDS)

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____ ID#: _____ GROUP #: _____

SECONDARY INSURANCE COMPANY: _____ ID#: _____ GROUP #: _____

***** INSURANCE WILL NOT COVER A DIAGNOSTIC EVALUATION FOR HARSHIP. *****

PATIENTS REQUIRING AN INTERPRETER

LANGUAGE: _____ *INTERPRETER* GENDER PREFERENCE? MALE: ☐ FEMALE: ☐ NO PREFERENCE: ☐

ADDITIONAL NOTES/COMMENTS

_____

_____

_____

PLEASE FAX OR EMAIL THIS COMPLETED FORM TO DR. SIGLER USING THE CONTACT INFORMATION BELOW

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