FOR OFFICE USE ONLY:

Authorization # _______________
# of Visits ____________________
Start Date ____________________

DR. SABRINA PINCKNEY, LPC, NCC

OUTPATIENT COUNSELING SERVICES

1963 HOLLINGS ROAD * JAMES ISLAND, SC 29412 * OFFICE 843-795-8212 * FAX 843-795-8212

DATE ___________________ **REFERRAL SOURCE** (AGENCY/PERSON) ______________________________

PHONE ____________________________ FAX NUMBER _____________________________

CLIENT'S NAME ____ DOB ______________

SOC. SEC. # ____________________ GENDER _______ AGE _______ RACE ________ ETHNICITY ________

IF CHILD, HAS CHILD BEEN IN SCHOOL WITHIN THE LAST 3 MONTHS? YES/NO CURRENT OR HIGHEST GRADE COMPLETED? _____
IF ADULT, WHAT IS THE HIGHEST GRADE COMPLETED? _______ HAS CLIENT BEEN ARRESTED IN LAST 30 DAYS? YES/NO # OF TIMES___

ADDRESS ____

HOME PHONE (______) _________________WORK HOME (_______) ________________________

□ **BIOLOGICAL PARENT** □ **LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)**

PARENT/GUARDIAN/OTHER ____

HOME PHONE (______) _________________ WORK HOME (_______) ________________________

REASON FOR REFERRAL:

____

____

____

WHAT GOALS WOULD YOU LIKE TO SEE ADDRESSED?

____

____

BILLING INFORMATION

Does client have Medicaid? Yes/No **MEDICAID #** ____________________________

PLEASE FAX THIS COMPLETED FORM TO (843) 795-8212 OR EMAIL TO pinckney.sabrina@yahoo
MAIL TO 1963 HOLLINGS ROAD, JAMES ISLAND, SC 29412