REFERRAL INTAKE FORM

REFERRAL SOURCE INFORMATION					
Name:				Date of Referral:	
Telephone:		Fax:		Email:	

CLIENT INFORMATION			Circle Gender: Female / Male				
Name:			Date of Birth:		SSN#:		
Street:		City:		State:		Zip Code:	
Home Phone:		Cell Phone:		Email:			
Emergency Contact Name:				Telephone:			
Relationship to client:	☐ Client	☐ Spouse/Partner	☐ Parent	☐ Legal Guardian	☐ Legal Custodian		

REFERRED FOR TYPE OF SERVICE	☐ Psychiatry/Medication Management	☐ Individual Therapy

INSURANCE					
Name on card:					
Primary Insurance Carrier:		Policy #:		Group #:	
Secondary Insurance Carrier:		Policy #:		Group #:	
CREDIT CARD PAYMENT					
Name on Card:		Card #:			
Exp Date:		Security Code:		Billing Zip Code:	
TELEHEALTH ACCESSIBILITY					
☐ Zoom	☐ Other	☐ Telephone	☐ Henderson (in-office)		
Notes:					

For Office Use Only-

TheraNest	Paperwork	
AdvancedMD	E&B Verification	Google Invite/Zoom