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# REFERRAL/CONSENT FOR MENTAL HEALTH SERVICES

**PATIENT INFORMATION**:

NAME: ______________________________ DATE OF BIRTH:______________________

SSN:__________________ GENDER: ____________ MARITAL STATUS_________________

PHYSICAL ADDRESS:________________________________)______________________

MAILING ADDRESS:__________________________________________________________

PHONE: HOME:___________________ WORK:_________________CELL:_______________

EMPLOYMENT: YES______ NO_____

**LEGAL GUARDIAN (if minor child):**____________________________ PHONE: ____________

ADDRESS:__________________________________________________________________

PRIMARY CARE PHYSICIAN_______________________________PHONE#:______________

**EMERGENCY CONTACT:**________________________________________________________

**EMERGENCY PHONE #:** _______________________________________________________

## INSURANCE INFORMATION:

PRIMARY INSURANCE ___________________________
POLICY#:_______________________________________
POLICY HOLDER NAME:__________________________
RELATIONSHIP:_________________________________
POLICY HOLDER DATE OF BIRTH:_________________
EFFECTIVE DATE:__________ COPAY AMOUNT:______
AUTHORIZATION #:______________________________
NUMBER OF VISITS________________:_____________

SECONDARY INSURANCE__________________________________
POLICY#_______________________________________________
POLICY HOLDER NAME:__________________________________
RELATIONSHIP:_________________________________________
POLICY HOLDER DATE OF BIRTH:__________________________
EFFECTIVE DATE:_________________ COPAY AMOUNT:______
AUTHORIZATION #:______________________________________
NUMBER OF VISITS______________:________________________

## Reason for visit______________________________________________

______________________________________________________________

______________________________ ______________________________
Signature of responsible party Date