



2126 E VICTORY DR | PMB 210 | SAVANNAH, GA, 31404 | OFFICE 912-259-8046 | FAX 912-724-7209

DATE \_\_\_\_\_

REFERRAL SOURCE (AGENCY/PERSON) \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

FAX NUMBER \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

CLIENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_

GENDER \_\_\_\_\_ AGE \_\_\_\_\_ RACE \_\_\_\_\_ ETHNICITY \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_

CELLPHONE (\_\_\_\_\_) \_\_\_\_\_

☐ BIOLOGICAL PARENT ☐ ADOPTIVE PARENT ☐ LEGAL GUARDIAN ☐ NOT APPLICABLE

PARENT/GUARDIAN/OTHER \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ WORK HOME (\_\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ OFFICE PHONE (\_\_\_\_\_) \_\_\_\_\_

**REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)**

☐ THERAPEUTIC MENTORING ☐ PARENT SUPPORT ☐ INDIVIDUAL THERAPY ☐ FAMILY THERAPY

**BRIEF DESCRIPTION OF PROBLEM** (ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

\_\_\_\_\_  
\_\_\_\_\_

**BILLING INFORMATION**

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_

POLICY # \_\_\_\_\_ AUTHORIZATION # \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ MEDICAID # \_\_\_\_\_

**DOES CLIENT HAVE ANY OTHER FORM OF INSURANCE? Yes/No**

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_

POLICY # \_\_\_\_\_ AUTHORIZATION # \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ MEDICAID # \_\_\_\_\_

**DOES CLIENT HAVE ANY OTHER FORM OF INSURANCE? Yes/No**

PLEASE FAX THIS COMPLETED FORM TO (912) 724-7209 OR  
EMAIL TO LASHAWNTUPER.LPC@GMAIL.COM