

Please complete and submit the following form for *clinical services*. The admissions coordinator will contact you by phone to schedule the appointment within 48 business hours upon receipt. We require that you provide at least two phone numbers. Thank you and we look forward to meeting with you and your child.

Today's Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_

We only bill insurance companies in which we are contracted and we do not bill secondary insurance. If we are not contracted with your insurance company, we are happy to provide a copy of the attending doctor's statement for you to submit to your insurance company. The admissions coordinator will go over this with you in more detail. Please contact us if you have any questions about this.

Reason for Referral: \_\_\_\_\_

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Other Concerns: \_\_\_\_\_

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Mother: \_\_\_\_\_ HM Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Address: \_\_\_\_\_

Father: \_\_\_\_\_ HM Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status:    Married        Divorced        Single        Other \_\_\_\_\_

If applicable, are you the custodial parent? \_\_\_\_\_