Behavioral Health

DATE: _____ ***Please email to: referrals@realpractices.net**

Client Information: **All requested information below is REQUIRED in order to provide services**

Client's Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

DOB: ____/_____/_____ **Age:** _____ **Race:** _____ **Gender:** _____

Social Security Number: _____ - _____ - _____ **Phone:** _____

***Reimbursement Source* (copy of cards will be needed):**

☐ **Medicaid** ☐ **PASSE** ☐ **Private Insurance** ☐ **Self Pay**

Insurance Name & Policy/ID Number(s): _____

If Private Insurance, Name of Insured: _____

Relationship to Client: _____ **Date of Birth of Insured:** _____

Primary Care Physician: _____ **Last PCP Visit (Month/Year)**: _____

Client's School: _____ **Client Grade:** _____

****If client is a minor, please complete the following:***
PARENT/GUARDIAN:
Name(s): _____

Is this person Legal guardian? ☐ **No** ☐ **Yes**

Phone Number: _____ **Email Address:** _____

Presenting Problem: _____

Referral Source: _____

Have you received services from another mental health provider within the past year? ☐ **No** ☐ **Yes**

Need for Interpretive Services? ☐ **No** ☐ **Yes** **Please specify language:** _____