

PATIENT REFERRAL FORM

Referred by _____ Date Referral Received _____

Street Address _____

Referral called in by _____ Phone _____

PATIENT NAME _____ **DOB** _____ **Age** _____

Responsible party, if other than patient

Relationship to patient

Address _____ City/State _____ ZIP _____

Home Phone _____ Work Phone _____

MVA? []Yes []No **If Yes, DOA** _____ **Head Injured?** []Yes []No - **If Yes, LOC?** []Yes []No []Don't know

Are you represented by an attorney? []Yes []No If YES, see other form.

Sending us medical records? []Yes []No Do we send directions to our office location? []No []Yes ___ Verbal ___ Mailed

Current Problems/Reason for Referral _____

Testing hours requested: _____ Testing hours authorized: _____

_____/_____/_____ Confirmed appt with _____ on _____
Appt day date time

PATIENT INFORMED: BRING \$ _____ COPAY 48-HR NOTICE ___ GLASSES/etc. ___ MEDS LIST ___

Payment Plan \$ _____ down/\$ _____/month

INSURANCE INFORMATION

Primary Ins. _____ Telephone # _____

Policy is in the name of (if other than patient) _____

ID # _____ Group # _____ Eff. Date: _____

Yearly deductible \$ _____ **Has deductible been met?** ____ Yes ____ No

Copay: \$ _____ per hr/unit ~~-or-~~ per visit - **Preauthorization No. DIINT** _____

PSYCH _____ hr/unit ____ **NEUROPSYCH** _____ hr/unit

Psychotherapy _____ hr/unit

Employer (if applicable) _____

Notes _____

File under Mental Health Benefits? ____ No ____ Yes file under Medical Benefits? ____ No ____ Yes

SEND CLAIM TO:

DIINT: _____

_____ TESTING (if different): _____

Telephone # if different from above: _____

Is there a **SECONDARY** insurance? ____ No ____ Yes - If Yes, get the following information:

Company name _____ Telephone # _____

Policy is in the name of _____

ID # _____ Group # _____

CLAIM TO: _____

Is there a **TERTIARY** Insurance? ____ No ____ Yes - If yes, get the following information:

Company Name: _____ Telephone _____

Policy is in the name of _____ ID# _____ Group _____

Claim TO: _____

IF IN LITIGATION:

PATIENT _____ Type of Litigation: _____

ATTY NAME _____ PHONE NO. _____

FIRM NAME _____

ADDRESS _____

CITY/STATE _____ ZIP _____

IS MEDPAY COVERING? []Yes []No - If yes, send medpay agreement form - Date form sent _____

NOTES _____

NEED "LTR OF REPRESENTATION" FROM ATTY (STATING THAT THEY REPRESENT THIS PERSON, REQUESTING COPY OF REPORT, IF DESIRED, ETC.)

Ltr in file _____ Called atty requesting ltr _____
(date)

NOTES _____

IF WORKERS' COMP:

REFERRAL SOURCE (must be **Primary Care** Physician, WC Approved Referral Source or representative from carrier):

EMPLOYER _____

STREET _____

CITY/STATE _____

TELEPHONE NO. _____
(Call before appt to confirm coverage)

Claim No. _____ Case Worker _____

SEND CLAIM TO (if other than Employer):
