REFERRAL FORM

Today's date:	New Client? Yes/No (circle one)

CLIENT INFORMATION

Last Name: First Name:	Middle Initial:	Marital status (circle one) Single / Married / Divorced / Separated / Widowed/ Partnered

Legal Guardian? (minors, etc) ❑ Yes ❑ No	Name of Guardian/Parent:	Race:	Religion:	DOB/Age:	Gender: ❑ M ❑ F

Home Address:

City:	State:	Zip Code:

Email Address:	Primary Phone:	Secondary Phone:

Referral Source: (name, address, phone number and email)

Reason for Referral: ❑ Individual Therapy (child/adolescent/adult/older adult) ❑ Family Therapy ❑ Couples Therapy ❑ Crisis Intervention ❑ Specialized Services/Financial Therapy ❑ Problem Gambling
❑ Other ___________________________

Briefly describe your reason for seeking therapy:

Please attach relevant information such as: legal document of guardianship, court reports, reports from previous evaluations, medical/psychiatric/hospital information and summaries.

INSURANCE INFORMATION

The following insurances and EAP plans are currently accepted: Humana Military, Tricare, Aetna, Magellan Health, Johns Hopkins Healthcare, Beacon Health Options, Maryland Medical Assistance/Medicaid, Medicare, CareFirst/BCBS, Cigna, Military One Source, Compsych/Guidance Experts & United Behavioral Health/Optum. Self-Pay options available

Person responsible for bill:	Birth date:	Address (if different):	Primary Phone: ( )
Occupation:	Referred by Employer?	Employer address:	Employer phone:

Is client covered by insurance? ❑ Yes ❑ No If no, Self-Pay options are available.

Primary Insurance Policy No.
Secondary Insurance Policy No. (if applicable)
Additional Insurance Policy No. (if applicable)

Client's relationship to subscriber: ❑ Self ❑Spouse ❑ Child ❑ Other ___________________________________

FOR OFFICE USE ONLY

Date Received:	Intake Scheduled:		Comments:

Money Talks Baltimore, LLC
Phone: 410-670-5889/ Fax: 443-687-8742
email:info@moneytalksbaltimore.com/website:www.moneytalksbaltimore.com