SAPIA PSYCHOLOGICAL ASSOCIATES, INC.
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Phone: 910-457-0800 Fax: 910-457-1072

REFERRAL/CONSENT FOR MENTAL HEALTH SERVICES

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH:_____

SSN:_____ GENDER: _____ MARITAL STATUS_____

PHYSICAL ADDRESS:_____)_____

MAILING ADDRESS:_____

PHONE: HOME:_____ WORK:_____CELL:_____

EMPLOYMENT: YES_____ NO_____

LEGAL GUARDIAN (if minor child):_____ PHONE: _____

ADDRESS:_____

EMERGENCY CONTACT:_____

EMERGENCY PHONE #: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____

POLICY#:_____

POLICY HOLDER NAME:_____

RELATIONSHIP:_____

POLICY HOLDER DATE OF BIRTH:_____

EFFECTIVE DATE:_____ COPAY AMOUNT:_____

AUTHORIZATION #:_____

NUMBER OF VISITS_____:_____

SECONDARY INSURANCE_____

POLICY#_____

POLICY HOLDER NAME:_____

RELATIONSHIP:_____

POLICY HOLDER DATE OF BIRTH:_____

EFFECTIVE DATE:_____ COPAY AMOUNT:_____

AUTHORIZATION #:_____

NUMBER OF VISITS_____:_____

REFERRAL SYMPTOMS:

_____

_____ _____

Signature of responsible party Date

* **Please attach photocopy of front and back of insurance card**