REFERRAL/ SCREENING FORM

Jefferson Comprehensive Counseling Associates

Client ID: _____

Today's date: _____ PCP: _____

CLIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____

Marital status (check one)
☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former or maiden name:	Birth Date (MM/DD/YY):	Age:	Sex: ☐ M ☐ F	Race:

Social Security #:	Home or Primary Phone #:	Cell or Alternate Phone #:	Guardian Name(s), if applicable:

Physical Address: _____
Address City State Zip Code

Occupation:	Employer or School, if student:	Employer phone #:

Chose clinic because/Referred to clinic by (please check one box): ☐Dr. _____ ☐ Insurance Plan ☐Hospital
☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Court: ☐ Other: _____

If Court Referred, please list Judge, County, and Probation/Parole Officer: _____

MEDICAL HISTORY/STATUS

Do you have any current health conditions? If yes, please explain: _____

Do you require any special accommodations? ☐ Yes ☐ No If yes, please explain: _____

Please list any known allergies (food, drug, etc) : _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO THE RECEPTIONIST.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone #:

Is this person a Client here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone #:

Is this Client covered by insurance? ☐ Yes ☐ No Please indicate primary insurance: _____

Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group #:	Member ID:	Co-payment:
					$_____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Member ID:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

MENTAL HEALTH CONDITIONS AND SYMPTOMS

☐Have you previously been diagnosed with a mental health condition? If so, what?
☐Are you prescribed psychiatric medications that you ❑ are ❑ are not taking currently?
Please describe current symptoms/problems and/or reason for referral to treatment:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Client:	Home phone #:	Work phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinician. I understand that I am financially responsible for any balance. I also authorize Jefferson Comprehensive Counseling Associates or insurance company to release any information required to process my claims.

_____ _____
Client/Guardian signature *Date*