Better Morning - Private Patient Referral Form

(Therapy & Medication Management)

Date: _____

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / _____

Gender: _____

Phone Number: _____

Email Address: _____

Address: _____

_____

Insurance Information

Insurance Provider: _____

Plan Type: _____

Policy / Member ID #: _____

Group #: _____

Primary Insured Name & DOB: _____

Authorization Required: [ ] Yes [ ] No

Co-pay Amount: $_____

Referral Source

Referred By: _____

Practice / Organization: _____

Phone: _____

Email: _____

Reason for Referral (check all that apply)

[ ] Anxiety

[ ] Depression

[ ] ADHD

[ ] Trauma / PTSD

[ ] Mood Disorder

[ ] Relationship / Family Concerns

[ ] Medication Evaluation

Better Morning - Private Patient Referral Form

(Therapy & Medication Management)

[ ] Medication Management

[ ] Other: _____

Requested Services

[ ] Individual Therapy

[ ] Family Therapy

[ ] Medication Evaluation & Management

[ ] Combined Therapy + Medication Management

Additional Notes / Relevant History

_____

_____

_____

Referral Submission

Fax: _____

Email: _____

Phone: _____

Better Morning - Every Day is a New Beginning