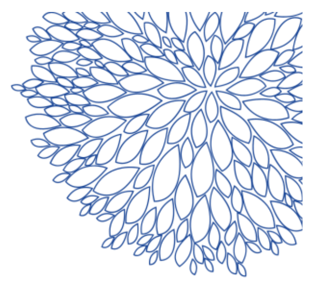
my therapy place



Child's Name: ____

CLIENT INFORMATION:

DOB: ____________ Gender: ____________

Client Phone: ____

Address: ____

Private Insurance: ☐BCBS ☐Cigna ☐Medcost ☐United Health Care/Optum ☐Aetna

Medicaid: ☐Healthy Blue ☐Wellcare ☐United Health Care Community Plan ☐AmeriHealth

☐Trillium ☐Partners ☐ Vaya Heath

☐United Health Care ☐No Insurance/Self-Pay

Insurance Member ID: ________________________________

LEGAL GUARDIAN INFORMATION:

Name: ____

Relationship to Child: ☐Biological Parent ☐Adoptive Parent ☐DSS ☐Other

**Any individual possessing legal guardianship other then the client's biological parent must produce legal documentation of guardianship at assessment.*

Parent/Legal Guardian Phone: ________________________________

Parent/Legal Guardian Email: ________________________________

REASON FOR REFERRAL:

☐Anxiety ☐Depression ☐Suicidal Ideations or Attempts ☐Hyperactivity/Impulsivity ☐Trauma

☐Behavior Difficulties at Home ☐Behavior Difficulties at School ☐Family Conflict ☐Other

Description: ____

____

Name/Title of Referral Source: ____

Phone and Email of Referral Source: ____

*Email to cmartintherapyplace@outlook.com or fax to 336-822-9463