Harmony Counseling Clinic

Referral Form

Client Name: _____ Initial Contact: _____

Parent Name: _____ Phone# _____

Client Address: _____

DOB: _____ SS#: _____

Primary Ins: _____ Secondary Ins: _____

Insurance ID#: _____ Insurance ID#: _____

Group#: _____ Group#: _____

Ref Doctor/PCP: _____

Reason for Services:

_____

_____

(If Adult, see Adult screening form)

(office use only)
Intake appointment: _____ Therapist: _____

Harmony Counseling Clinic
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Email: office@harmonycounselingclinic.com