Counseling and Wellness Services

Referral form for Services

Complete form and fax. We will contact the client and advise you of the outcome.

Date: _____

Referral from: _____

Phone: _____ Fax: _____

Patient's name: _____ DOB: _____

Parent or guardian (if applicable): _____

Phone: _____

Service requested: _____ Individual psychotherapy
_____ Couples/Family therapy

Specific concerns/requests/recommendations:

Payor source: (Please note: NO MEDICAID)

____BCBS ____Medicare ____UHC/Optum/UMR
____ Medcost ____ Cigna
_____Tricare ____ Self-Pay
Other: _____

Please attach copies of insurance cards.

OUR TEAM:

Debra Peters, PhD, Cindy Peters, PhD, Kim Harshaw, MS, LCMHC,
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PLEASE SEND ANY RELEVANT RECORDS. THANK YOU FOR YOUR REFERRAL.

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