METTA COUNSELING SERVICES

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WWW.METTA-COUNSELING.COM

EMAIL COMPLETED REFERRAL TO METTA@METTA-COUNSELING.COM

REFERRAL / SERVICE AGREEMENT

Client Name:				Date of Referral:		Gender:	
Age:		DOB:		SSN:		Ethnicity	
Current Residence:							
Home Phone:		School:				Grade:	
Parent / Guardian:				Relationship to Client:			
Work Phone:				Cell Phone:			
Parent Address (if different from **Current Residence** above):							
Referring Agency (include full mailing address):				Name:			
				Phone:			
				Email:			
Reason for Referral (include present concerns):							
Goals Outlined by Referring Agency:							
PRIORITY:	Emergency:		High:		Average:		Low:

Indicate Services Requested			**Private Insurance** (include policy and group number, primary policy holder):	
TYPE OF SERVICE				
Office Based Therapy:			**FUNDING SOURCE**	
Family Therapy				
Individual Therapy			Other:	
Couples Counseling			Private Pay:	
			Private Insurance:	

The above named **Billing Agency** authorizes METTA COUNSELING SERVICES to provide the listed services to the above named client and is responsible for payment of these services. METTA COUNSELING SERVICES agrees to provide the listed services throughout the contract period unless a revised agreement is negotiated.

Received By:		Date:			