A NEW DAY COUNSELING, INC.

Quail Ridge Towers
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Phone/Fax: (405) 708-6331

REFERRAL AND SCREENING FORM

Thank you for choosing ANDC for a potential mental health partner. We need the following information in order to proceed with services.
PLEASE EMAIL, FAX, OR CALL THE OFFICE WHEN TURNING IN A NEW REFERRAL. PHONE/FAX: (405) 708-6331 OR INFO@ANEWDAYOK.COM

DATE: _____ Email Address: _____Electronic Correspondence OK: Yes☐ No☐

SOURCE OF REFERRAL: Health Plan _____ PCP _____ School _____ DHS _____ Other _____
NAME AND RELATION OF PERSON MAKING THE REFERRAL: _____
(PLEASE FILL OUT AS MUCH CONTACT INFORMATION AS POSSIBLE, AN INTAKE COORDINATOR WILL CONTACT YOU OR NEW REFERRAL W/IN 1 BUSINESS DAY)

NAME OF REFERRAL: _____ **DATE OF BIRTH:** _____ **SS#:** _____
Parent/Guardian: _____ **CONTACT #:** _____
ADDRESS: _____ **ZIP:** _____ **PHONE #:** _____
(Preferred contact number **circled above** and/or verbal permission to leave a message. Yes☐ No☐

If child, Name of School: _____

What is your Concern? Reason for services?: _____

Payment Source , Insurance Information, & Payment options:

In Network ☐ Out of Network (self Pay) ☐ or Private Pay ☐

If we are In-Network with your insurance company, you are responsible for contacting your insurance company for coverage amounts. We must have a copy of the front & back of your insurance card prior to the start of services.

Your deductible is the amount you must pay before your insurance company will begin paying for or 'covering' your services. This will be charged to your credit/debit card for each visit (you can also use cash).

Insurance Company: _____ **Name of policy holder:** _____
Insurance Plan ID #: _____ **Group ID #:** _____
Current Deductible Amount Owed: $_____ **Co-pay due for each session: $**_____

Out of Network: If we are out of network, you can use a "superbill" to turn in your own insurance claim.

Self Pay or Private Pay: If we are not in-network with your insurance company or you do not have private insurance, you are considered a self pay client. You are responsible for all charges.

----------Do not write below, for staff----------

REFERRAL TAKEN BY: _____ **REFERRED TO:** _____

BH: Yes☐ No☐ Gambling: Yes☐ No: ☐ SAS/INTEGRATED: Yes☐ No☐ TRAUMA: Yes☐ No☐

DATE OF 1ST SCHEDULED APPOINTMENT OFFERED: _____ **INTAKE COMPLETED:** Yes ☐ or No Show ☐
(If declining referral give reason and disposition: (_____)

Assigned Counselor Signature: _____ Date: _____
ADDITIONAL NOTES: (Staffing held to consult on client needs or other additional notes)
_____
_____