Collaborative Change

NEW CLIENT REFERRAL FORM

Please fax 317-203-0955 or email info@collaborative-change.com this form back to us

Date

Client Information:

Last Name | First Name | MI | Date of Birth | Preferred Pronoun

Street Address | City | State | Zip

Home Phone | Work Phone | Cell Phone | Email

Parent/Guardian Name:

Preferred Service Location

☐ North Side Office (10293 N. Meridian St, 46290

☐ West Side Office (3073 Salt Lake Road, 46214)

Insurance Information of Referral: *If insurance information is inaccurate or incomplete it will be returned to referral source

Primary Insurance:

Insurance Name:_____

Insurance Id#: _____

Insurance Group #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Secondary Insurance:

Insurance Name: _____

Insurance Id#: _____

Insurance Group #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Primary Concerns (Please check all that apply):

Family Problems
Depression
Self-Confidence
School Concerns
Alcohol/Substance Abuse
Grief/Loss
Anxiety/Worry
Abuse/Trauma
Behavioral Concerns
Other

Preferred Days to Meet with Therapist

Monday
Tuesday
Wednesday
Thursday
Friday

Preferred Times to Meet with Therapist

8:00 am-12:00 pm
12:00 pm-4:00 pm
4:00 pm-7:00 pm
Anytime

Any additional comments:

Contact Information for Referral Source (Name and phone/email):