

Healing Therapeutic Services, LLC

REFERRAL INTAKE FORM

Date: _____

Referring person and agency: _____

CLIENT INFORMATION

Name: _____

First, MI, Last

DOB: _____ Male { } or Female { }

Street Address: _____

City, State, Zip Code: _____

Phone – Home: _____

Work: _____

Cell: _____

Preferred Daytime Phone #: **H** { } **W** { } **C** { }

Client would like us to call to schedule { } Client will call to schedule { }

Is Client in Crisis: { } Yes or { } No

Status: Child { } Single { } Married { }

Separated { } Divorced { } Widowed { }

Presenting Problem(s) and notes: _____

IF CLIENT IS A MINOR – Responsible Party or Legal Guardian Information

Name: _____

First, MI, Last

Address (if different): _____

City, State, Zip Code: _____

Relationship to Client: _____

If available:

MAA # _____ Insurance Plan _____

Group No: _____ Subscriber ID # _____

Policyholder: _____ DOB: _____ Relationship to Client _____

Additional Notes:

Please include Assessment and Safety Plan with referral if available

REFERRAL AND CASE COORDINATION AUTHORIZATION

Section 1

Client Name: _____ Date of Birth: _____

Referring Agency or Person: _____

Section 2

I authorize the Referring Agency or Person (above) and the staff of Healing Therapeutic Services, LLC to exchange information regarding my referral or ongoing care. Documentation may be released as indicated below (Section 3). I understand that information disclosed in referral, consultation, or care coordination will be considered confidential and not re-released to third parties.

Clinicians included in the scope of this release:

Alan Davis, LMFT Brian Putz, MA LP Jennifer Zenz-Olson, LICSW Romy Sundem, LMFT
 All HTS, LLC clinicians and staff.

Section 3

Description of Information to be Disclosed

<input type="checkbox"/> Diagnostic Assessment/Evaluation	<input type="checkbox"/> Treatment Plan or Summary
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Safety Plan
<input type="checkbox"/> Psychological Assessment	<input type="checkbox"/> School Records
<input type="checkbox"/> All Mental Health Information-Dates of Service _____	
<input type="checkbox"/> Other-specify _____	

Section 4

The Purpose of this Disclosure of information:

Referral Case Coordination Other – Specify _____

Section 5

*I understand that information will be disclosed that is protected by Federal Laws and Minnesota Statutes. I understand that I have a right to revoke this authorization at any time, in writing, but that the revocation will not have any effect on the information released prior to notification of cancellation. If I refuse to sign this consent, treatment will not be withheld. I understand that this consent **expires ONE YEAR** after signature date.*

I release Healing Therapeutic Services, LLC from any and all liability resulting from disclosure. I do not authorize re-release of this information to anyone. I have read this consent prior to signing and I understand its contents.

Signed _____ Date _____
Signature of Client or *Legal Guardian/Responsible Party if under 18

*Relationship to Client _____

Witness _____ Date _____
