Referral Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____

Zip Code: _____ Preferred Phone Number: _____ Alternative Phone Number: _____

May we leave a voicemail message at your preferred number?
○ Yes ○ No

May we send text message reminders at your preferred number?
☐ Yes ☐ No

When is the best time to contact you to schedule an appointment?
_____

Email:
_____

If Child, Who is able to make appointments:
_____

If Adult, Do you have a Legal Guardian? If so whom?
_____

2. Reasons for seeking therapy services?

_____

3. Therapy Preferences;

Preferred Therapist:
☐ Stacy Kriese ☐ Alex Gregory (Cold Spring Only) ☐ Noel Kern ☐ Carrie Gapinski ☐ Rachel Gross
☐ Rachel Trout ☐ Rebecca Cluever ☐ Jill Williams ☐ Jennifer Lund (Cold Spring & Sauk Rapids)
☐ Emily Meyer (Cold Spring & Sauk Rapids) ☐ Katrina Phifer (intern) ☐ Jessica Elfering (intern)
☐ No Preference

Preferred Location:
☐ Sauk Rapids ☐ Cold Spring ☐ No Preference

Preferred Therapeutic Intervention:
☐ Individual Therapy ☐ Couples Therapy ☐ Family Therapy ☐ Parent Child Therapy
☐ Trauma-Informed Care ☐ No Preference/ Other

4. Do you have Medical Insurance?

○ Yes ○ No

Other Form of Payment:

_____

5. Primary Insurance

Primary Insurance Company _____ ID # _____ Group # _____

Do you have Secondary Insurance?

○ Yes ○ No

6. Secondary Insurance

Secondary Insurance Company _____ Individual # _____ Group # _____

7. Other details for our scheduling team/ therapist? (Specific days or times need)

_____

I authorize the release of any medical information necessary to process my claim and payment of benefits.

_____ _____

Signature Date