SYNERGY COUNSELING
OF GREENWOOD
Your Path To A Better Life

REFERRAL FORM

Referring Agency: _____ Referral Date: _____

Referral Source Name: _____ Source Contact Number: _____

Referred Client Information:

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Please Check One: Home __ Cell __ Work __

SSN: _____ DOB: Month _____ Day _____ Year _____

Primary Form of Insurance: _____ ID#: _____

*Please keep in mind that currently we are ONLY in network with First Choice Select Health Medicaid, Medicaid, Aetna, and Cigna. We apologize for any inconvenience that this may cause. *

Will the agency be paying for the services? Please check one: Yes ____ No ____ Partial Payment _____ (What amount is the client responsible for?)

Please describe in as much detail as possible your reasons for referring this client:
_____
_____
_____
_____
_____

SYNERGY COUNSELING OF GREENWOOD, LLC
Physical Address: 101 Cambridge Ave. E, Greenwood, SC 29646
Mailing Address: PO BOX 49895, Greenwood, SC 29649
Tel: (864) 223-2243 | Fax: (864) 223-3044
Email: admin@synergycounselinggreenwood.com | Website: synergycounselinggreenwood.com

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Treatment Services Requested, please indicate number of sessions approved and how many per week:

Mental Health Counseling:	Anger Management:	Domestic Violence (Victim):	TESTING: Psychoeducational Assessment–Cognitive Only
Substance Abuse Treatment:	Couples Counseling:	Domestic Violence (Aggressor):	TESTING: Full Psychological Assessment-Cognitive and Personality
Parenting Classes:	Medication Management:	Grief Counseling:	Co-Parenting Classes:
Family Counseling:	Other:	Other:	Telehealth Visits: Y/N

Please Attach ANY Supporting Documents:

- Court Order
- Safety Plan
- Medical Release Form
- Previous Records

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