SYNERGY COUNSELING

OF GREENWOOD

Your Path To A Better Life

Referral Form

Date of Referral: ____________________

Referred Client information

Client Name: Last________________________ First____________________ M.I. ______

Client Address: ____

City: ___________________ **State:** ___________ **Zip Code**_____________

Client Phone # ___________________________

Client SSN: ______________________ **Client DOB:** ______________________

Primary Form of Insurance: ____________________________ **ID#:** _________________

Secondary Form of Insurance: __________________________ **ID#**__________________

Tertiary Form of Insurance: ____________________________ **ID#**__________________

We do **NOT** accept **Absolute Total Care, Medicare, Cenpatico, Tricare,** or **United Healthcare**

Treatment services to which you have referred client: _____Substance Abuse; _____Mental Health Counseling; _____ Parenting classes; ____Medical Care; ___________ Other

Please describe in as much detail as to why you are referring this client:

____

____

____

____

____

____

Referral Source Name: _______________

Fax #_____________________

Office #___________________

101 East Cambridge Ave, Greenwood, SC 29646 · Tel: (864) 223-2243 · Fax: (864) 223-3044
Email: admin@synergycounselinggreenwood.com · Website: www.synergycounselinggreenwood.com