FOR OFFICE USE ONLY:
Authorization # _____
# of Visits _____
Start Date _____

APHIA HEALTH AND WELLNESS SOLUTIONS

2001 MLK JR. DR. * SUITE 450-A * ATLANTA, GA 30310* OFFICE 404-551-5654 * FAX 404-551-5570

DATE _____

REFERRAL SOURCE (AGENCY/PERSON) _____

ADDRESS _____ PHONE _____

FAX NUMBER _____ EMAIL ADDRESS_____

CLIENT'S NAME _____ DOB _____

SOC. SEC. # _____GENDER _____ AGE _____ RACE _____

ADDRESS _____

HOME PHONE (_____) _____ WORK HOME (_____) _____

□ **BIOLOGICIAL PARENT** □ **LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)**

PARENT/GUARDIAN/OTHER _____

HOME PHONE (_____) _____ WORK HOME (_____) _____

EMERGENCY CONTACT _____

HOME PHONE (_____) _____ WORK HOME (_____) _____

ATTORNEY (IF APPLICABLE) _____

ADDRESS _____ OFFICE PHONE (_____) _____

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

☐ THERAPEUTIC MENTORING ☐ PARENT SUPPORT ☐ INDIVIDUAL THERAPY ☐ FAMILY THERAPY
☐ GROUP THERAPY ☐ PSYCHIATRIC EVALUATION ☐ TESTING
☐ COUPLES THERAPY

BRIEF DESCRIPTION OF PROBLEM (ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

_____

_____

_____

_____

_____

_____

BILLING INFORMATION

PRIMARY INSURANCE COMPANY _____

POLICY # _____ GROUP # _____ PHONE (_____) _____
NAME OF INSURED _____ MEDICAID # _____
DOES CLIENT HAVE ANY OTHER FORM OF INSURANCE? YES/NO

FAX THIS COMPLETED FORM TO (404) 551-5570 OR
MAIL TO 2001 MARTIN LUTHER KING JR. DR. SUITE 450-A
ATLANTA, GA 30310