Shelby Wellness & Therapy Center, PLLC

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REFERRED TO LOCATION: ☐ SHELBY ☐ LINCOLNTON

REFERRAL DATE:	REFERRED BY:
AGENCY/CLINICIAN:	PHONE
☐ Check box to request reply w/appointment date.	EMAIL
	FAX:

IS YOUR AGENCY FINANCIALLY RESPONSIBLE FOR THIS CLIENT? YES or NO (circle one)

CLIENT NAME:
_____

AGE & DOB:
_____

CONTACT INFORMATION:
_____

INSURANCE TYPE:
_____

POLICY#/MEMBER ID#
_____

☐ CHECK BOX FOR SELF-PAY

REASON FOR REFERRAL / REFERRING DIAGNOSIS:

PLEASE INCLUDE RELEASE OF INFORMATION AND COPY OF INSURANCE CARDS