ASSOCIATES IN PSYCHOLOGY & THERAPY, INC.
APT., INC.
EAST HILLS PROFESSIONAL BUILDING
5185 ROUTE 60 EAST, SUITE 32
HUNTINGTON, WV 25705
PHONE: 304.302.0526
FAX: 304.302.0527
EMAIL: apt.inc.wv@gmail.com

REFERRAL FORM

Date: _____ Co-Pay: $_____

Name: _____Date of Birth: _____
(Last) (First) (Initial)

Age: _____ Sex: M____ F_____ Marital Status: ___S ___M ___D ___W ___O

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Soc. Sec. # _____

Cell Phone: _____ Work Phone: _____

Employer: _____
(Name) (Street) (City) (State & Zip)

Emergency Contact Person: _____
(Name) (Relationship) (Phone)

Reason for Visit:

___ Psychological Evaluation ___Pre-Surgical Evaluation ___Pre-Employment Evaluation

___Therapy/Counseling ___Educational Assessment ___ADHD/ADD Evaluation

___IQ Testing Only ___Autism Evaluation ___Hypnotherapy

___Trauma Counseling ___Other: ___Neuropsych Evaluation

___ Pediatric Occupational Therapy

Referral Source: _____
(Name) (Phone/Fax)

Billing Insurance Company: Person Responsible for Paying this Bill

Name: _____ Relationship to Patient: _____

Street: _____ City/State/Zip: _____

Phone: _____

Primary Insurance Company: _____Policy #: _____

Group #: _____ Street: _____City/State/Zip: _____

Policy Holder:_____ Relationship to Patient: _____
(Name)
DOB:_____

Secondary Insurance Company: _____Policy #: _____

Group #: _____ Street: _____City/State/Zip: _____

Policy Holder:_____ Relationship to Patient: _____
(Name)
DOB:_____

I hereby consent to treatment by the providers and/or associates of Associates in Psychology & Therapy, Inc.

Signature: _____ Date: _____

I hereby assign my insurance benefits to be paid directly to: Associates in Psychology & Therapy, Inc. I understand that I am financially responsible for all charges no covered by this assignment.

Signature: _____ Date: _____

Office use Only:

Scheduled with: _____ Date/Time: _____

Paperwork Mailed/Faxed/Picked up: _____

Insurance Verified: Date: _____ By: _____