Therapeutic Solutions Professional Counseling Group
201 S. McPherson Church Rd, Suite 202
Fayetteville, NC 28303
Office#: 910-916-6657 - Fax#:910- 920-2420

Patient Referral Form

Physican's Office: ___________________________

Client Name: ____ DOB: ________________

Client Contact #: ____

Concern and reason for referral: ____

Medications: Yes No

Insurance/Payment Information (We currently accept the below named insurances. We also accept cash, debit and credit.

Please circle one: Tricare, Medicaid- Alliance, Medicaid- Sandhills, NC Health Choice, Aetna, Blue Cross Blue Shield

Person Responsible for Payment: _________________________________ Relationship to client: _______________________________

Primary Insurance____Secondary Insurance: _______________________________

Policy# (Social of Sponsor if Tricare):__________________________Policy# (Social of Sponsor if Tricare):_______________

DOB of Subscriber:____DOB of Subscriber:_____________________________________

Counselor is requesting the following for "CLIENT" to receive Counseling Services:

1.____
Physician's Office Carolina Access NPI Number

2. ____
Physician's Printed Name

3.____ ___________
Physician's Signature for Authorization Date:

Please Fax Correspondence to:

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