

CLIENT REFERRAL INFORMATION



CLIENT INFO

Date: _____ **Must be completed prior to scheduling evaluation*

Client First Name: _____ <input type="checkbox"/> Auto/Workers Comp <input type="checkbox"/> Self Pay Address _____ State: _____ Home Phone: _____ Guardian Phone: _____ Date of Injury: _____	Client Last Name: _____ Email: _____ Guardian: _____ City: _____ Zip: _____ Mobile Phone: _____ DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Case Manager: <input type="checkbox"/> Yes <input type="checkbox"/> No Internal Case Manager: _____ Fax: _____ External Case Manager: _____ Fax: _____	Phone: _____ Email: _____ Phone: _____ Email: _____
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REFERRING PHYSICIAN INFO

Referring Person: _____ Group/Company Name: _____ Phone: _____ Fax: _____	Diagnosis: _____ Diagnosis code: _____ Prescription for YogaMedics Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Therapist Gender Preference: <input type="checkbox"/> Male <input type="checkbox"/> Female	Location Preference: <input type="checkbox"/> YMBH <input type="checkbox"/> YSWB <input type="checkbox"/> YMFH <input type="checkbox"/> Home/Other:					
Days/Times Available:						
	Mon	Tue	Wed	Thurs	Fri	Sat
am						
pm						

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PAYOR SOURCE INFO

Primary Insurance: _____
Policy Holder: _____ Policy Holder DOB: _____ Employer: _____
Enrollee ID #: _____ Group # _____ Employer Address: _____
Claim Address: _____
Adjuster: _____
Adjuster Phone: _____

Secondary Insurance: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Claim #: _____
Claim Address: _____
Adjuster: _____
Adjuster Phone: _____ PO Box 30512

Office Use Only
Notes: _____

Next Steps:

- Obtain Script
- Call Case Manager
- Call Adjuster
- Assign Therapist
- Create YMO and MBO Account
- Schedule Evaluation through CM if applicable
- Confirmation call on eval appt (w/ CM if applicable)