Change for Living COUNSELING, PLLC

Michelle Topal, MSW, LCSW

Date:_____ Name of Referring Provider:_____

Client Name:_____ Client/Parent Phone*:_____

☐ Check if Patient has Agreed for Us to Call Them *

Client Mailing Address:

Street:_____ City:_____ Zip:_____

Client Email: _____ Client DOB:_____

Parent's Name (if client is under 18 y/o): _____

Clinical Info:

Primary Concerns/Reason for Referral:_____

_____

_____

_____

_____

_____

_____

☐ **Check if sending Intake Evaluation and/or notes.**

Client Wants to Use Insurance?* ☐ **No** ☐ **Yes**

If yes, which Insurance company: _____

Subscriber Number _____ Group Number:_____

Name of primary Insured & DOB, if not client:_____

*Note: I am only in network with Medcost. We will review options with them when they call.

Secure Fax to: 888.789.5440 **Call: 919.807.1454**

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