FOR OFFICE USE ONLY:

Authorization _____

#ofVisits _____

Start Date _____

Option To Success Family Services

REFERRAL SOURCE (AGENCY/PERSON): _____

ADDRESS: _____

PHONE: _____ FAX NUMBER: _____

EMAIL ADDRES_____

CLIENT'S NAME: _____ DOB: _____

SOC. SEC. #:_____ GENDER: _____ AGE: _____ RACE:_____ ETHNICITY: _____

ADDRESS: _____ HOME PHONE:_____ WORK PHONE:_____

WHAT IS CURRENT OR HIGHEST GRADE COMPLETED?_____

BIOLOGICAL PARENT/ LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)

PARENT/GUARDIAN/OTHER: _____

HOME PHONE: _____ WORK PHONE:_____

EMERGENCY CONTACT: _____

HOME PHONE:_____ WORK PHONE: _____

ATTORNEY (IF APPLICABLE): _____

ADDRESS: _____ OFFICE PHONE: _____

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY):

□ THERAPEUTIC DAY TREATMENT □ COMMUNITY SUPPORT □ INDIVIDUAL THERAPY □ FAMILY THERAPY □ GROUP THERAPY
□ CASE MANAGEMENT □ PSYCHIATRIC EVALUATION □ MEDICATION ASSESSMENT □ MEDICATION MANAGEMENT

BRIEF DESCRIPTION OF PROBLEM (ATTACH SEPARATE SHEET/DOCUMENT IF NECESSARY.)

_____

_____

_____

_____

BILLING INFORMATION

PRIMARY INSURANCE COMPANY: _____

POLICY #: _____ AUTHORIZATION #: _____ PHONE: _____

NAME OF INSURED: _____ MEDICAID #: _____

DOES CLIENT HAVE ANY OTHER FORM OF INSURANCE? YES/NO

PLEASE EMAIL, FAX, OR MAIL THIS COMPLETED FORM TO:
EMAIL: INFO@OTSFS.ORG
FAX: 502-371-2279
MAIL: 3155 COMMERCE CENTER PLACE LOUISVILLE, KY 40216

Ver. 1/2019