To be Complete by ACC:
Date Assigned:
Therapist Assigned:
Office:

Appalachian
COUNSELING CENTER

OUTPATIENT THERAPY REFERRAL FORM

Date of Referral: ___________ **Therapist Requested:** ____________________
Office: (Fairmont/Huntington/ Virtual) ______________________________________

Referral Source: __________________________________ **Phone:** ______________________________________

Patient Name: ____ **DOB:** ___________ **Age:** _____________
Parent Name (if minor) ____
Address: ____

Phone Number (parent's if minor): ___________________ **Alternate Phone Number:** _________________________

Ok to leave message: ☐Yes ☐No **Ok to leave message:** ☐Yes ☐No

Person to be contacted for appointments: _________________________________ **Phone:** ____________________

Service Requested: Individual Family Couples **Counselor Preference:** Male Female None

Presenting Issue: ____

Preference for Appointments: Morning Afternoon Evening None Other: _______________________

Preference for Appointments: Telehealth Face-to-Face No Preference

INSURANCE INFO
Insurance Carrier: _________________________ **Policy Number:** ______________________________________

Secondary Insurance: ____________________________ **Policy Number:** __________________________________

Subscriber Name: ________________________________ **Subscriber DOB:** ______________________________

Subscriber Address: ____

Additional Comments:
____

Referrals can be faxed to the Fairmont Office at 681-404-6871

Appalachian Counseling Center
Fairmont Center
207 Fairmont Ave
Fairmont, WV 26554
681.404.6869 | 681-404-6871 (fax)
hello@wvcounseling.com

Appalachian Counseling Center
Huntington Center

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6/16/2022

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