GMA INTERVENTIONS, LLC
REFERRAL/INITIAL CONTACT FORM

(Please Print)

Today's Date:	Time of Appointment:	GMA Client Number (for staff only):

CLIENT INFORMATION

Last name:	First name:	Middle:	Marital status:	☐ Do not contact by phone ☐ Do not contact by email ☐ Do not contact by text message

Race:	Ethnicity: ☐ Hispanic ☐ Not Hispanic	Preferred Language:	Birth date: / /	Age:	Sex: ☐ Male ☐ Female

Social Security no.:	Home phone no.: ( )	Cell phone no: ( )	Preferred phone no: ☐ Home ☐ Cell

Street Address:	City:	State:	ZIP Code:

Email Address:	Occupation:	Employer:	☐ Part-time ☐ Full-time

Referred by:
☐ Self ☐ ASAP ☐ Probation & Parole ☐ Social Services ☐ Court ☐ Community Corrections/Pretrial ☐ SAIP ☐ Schools
☐ Other_____

Name of Case Worker/Manager/ Probation Officer (if applicable): _____

Service Requested:

PAYMENT INFORMATION (FILL OUT ONLY IF USING INSURANCE FOR PAYMENT)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a client here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this client covered by insurance? ☐ Yes ☐ No Name of Insurance:

Payment/Funding Source:	If vendor, specify:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.: Policy no.:	Co-payment: $

Client's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Legal Guardian Name (if applicable)	Address:	Phone No.: ( )	Alternate: ( )

Representative Payee:	Phone No.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to client:	Home/Cell phone no: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to GMA. I understand that I am financially responsible for any balance. I also authorize GMA Interventions or insurance company to release any information required to process my claims.

Client/Guardian Signature:	***Date:***