

Limitless Counseling Services (LCS) LLC

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Referral Form

****Please send releases of information, demographic information, evaluations, and/or any pertinent collateral information when/if appropriate to assist with care.****

Today's Date: _____**Request:** ___Urgent ___Routine

Client Name: _____ DOB: _____ Age: _____

Client Phone: _____ Client SSN: _____ (To verify insurance)

Address: _____

Email: _____ Previous Client: ___ Yes ___ No

Primary Insurance _____**Secondary Insurance** _____
(if applicable)

Member ID: _____

Member ID: _____

Group # _____

Group # _____

Ins Policy Holder Information _____
(Name, DOB, SSN):**Appointment Preference: (Mark all that apply)** ***Please understand that this is considered, not guaranteed. ***

<input type="checkbox"/> Monday	<input type="checkbox"/> Mornings	<input type="checkbox"/> In-Person
<input type="checkbox"/> Tuesday	<input type="checkbox"/> Evenings	<input type="checkbox"/> Teletherapy
<input type="checkbox"/> Wednesday	<input type="checkbox"/> Afternoons	<input type="checkbox"/> Both (In-person or Teletherapy)
<input type="checkbox"/> Thursday	<input type="checkbox"/> Anytime	
<input type="checkbox"/> Any Day		

Reasons Seeking Treatment: (Mark all that apply)

<input type="checkbox"/> Depression/Depressed Mood	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Trauma
<input type="checkbox"/> Abuse/Neglect	<input type="checkbox"/> Substance Use	<input type="checkbox"/> Life Transitions
<input type="checkbox"/> Pending Divorce/Dissolution	<input type="checkbox"/> Stress	<input type="checkbox"/> Grief Issues
<input type="checkbox"/> School/Work-Related Issues	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Provider Referred
<input type="checkbox"/> Mandatory Referral from Employer	<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> Relationship Issues
<input type="checkbox"/> EAP Referral or Ohio ASSIST	<input type="checkbox"/> Dual Diagnosis	<input type="checkbox"/> Skill Building
<input type="checkbox"/> Court Ordered Treatment	<input type="checkbox"/> Aftercare	<input type="checkbox"/> Medication Assisted Tx
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Referred by Doctor	

Additional Information/Comments: _____

Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 [HIPAA], 45 C.F.R., parts 160 and 164. [These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.]