Say It With Clay Referral Form

(please print)

Today's date:

CLIENT INFORMATION

Client's last name:	First:	M.I.:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Special needs? ❑ Yes ❑ No	Who referred?	Agency?	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone #: ( )	Cell phone #: ( )

City:	State/ZIP:	Best time to call:

Notification Preference: Phone Email Text	Email address:

Instructor preference (if applicable):
❑ Female
❑ Male

Areas of Focus/Reason for Referral:

Any prior experience with Art Therapy?

Any sensory sensitivities? (i.e. disliking certain textures, smells or sounds)

HEALTH AND INSURANCE INFORMATION

Person responsible for bill:	Address (if different):	Home phone #: ( )

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is the client covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance Policy #

Other Therapies:	Agency:	Co-payment: $

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

Current Medications (if applicable):	Prescribing doctor:

Intake to be scheduled with:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone #: ( )	Mobile phone #: ( )

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

Patient/Guardian signature *Date*