**A**lternative
**B**ehavioral
**C**oncepts, Inc.

# Referral Form

*PO Box 1057*
*Lake Alfred, Fl. 33850*
*Phone: 863-551-3300*
*Fax: 863-551-3301*

1. Funding Source
2. Your Name Title
3. Who are you referring?
   - SS# - - DOB / / Sex
   - Address City,State Zip
   - Phone Number( ) Alternate Number( )
   - Email Address
   - Availability(list available time for each day): Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday
4. Insurance Company Member ID
   - Insurance Phone #( ) Contact Name
   - Diagnosis
   - Behaviors of Concern
5. Does client attend a school or ADT? If so, which one?

6. Parent's or Guardian's Name

   - Address City, State Zip
   - Phone Number ( ) Alternate Number ( )
   - Should we contact them?

7. Who do we send the bill to? *

   - Address City, State Zip
   - Phone Number( )
   - Contact Person
   - Special Billing Instructions
   - Email Address

8. After requested service(s) are complete, what person's should meet, review, approve or receive copies of the report?

   - Name
   - Agency
   - Address City, State Zip
   - Phone Number ( ) Use back or attach separate sheet if you need more space.
   - Email Address

9. Is there anyone else we need to contact/coordinate with?

   - Agency Name
   - Contact Number ( ) Do they expect our call? Yes or No.

- Email Address

10. In the event of an emergency, whom should we contact?

- Name Telephone Number( )
- Address City, State Zip

- No need to complete section seven if we have a current contract on file with you. **Unless noted in special billing instructions section you will be billed $100.00 per hour ($25 per ¼ hour). ***This is to be considered a legal and binding contract for service(s) and you agree to pay for all services in full at the end of each billing period.

Signature Title Date