BrainPower
Neurodevelopmental Center LLC

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812-961-6546
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www.brainpowerneuro.com

Thank you for choosing to refer your patient to BrainPower Neurodevelopmental Center LLC. In order to best serve you and assist your patient, please fill out the following information.

1. Today's Date: _____

Name of Referring Physician: _____

Name of Person Completing Form: _____ Title/Position: _____

Name of Agency/Organization: _____

Address: _____

Your Phone Number: _____ Your Fax Number: _____

2. Information About Patient

Patient's Name: _____ Language Spoken (if not English) _____

Patient's Date of Birth: _____ Patient's SSN _____ Patient Biological Sex ○ Male ○ Female

Parents'/Caregivers' Names & Relationship to Patient: _____

Address Line 1: _____

City _____ State _____ Zip Code _____

Mobile Phone Number: _____ Home Phone Number: _____

Work Phone Number: _____ Email Address: _____

3. Referral Information

Referral for:

☐ Psychological Assessment ☐ PCIT Therapy

Please Indicate Your Concerns:

☐ Autism Spectrum Disorder ☐ ADHD ☐ Developmental Delay ☐ Disruptive Behaviors ☐ Parenting
☐ Intellectual Disability ☐ Anxiety ☐ Depression ☐ School/Academic Concerns
☐ Other _____

Current Medications

_____

Client Payment Method

☐ Private Insurance ☐ Medicaid ☐ Self Pay

4. Insurance Information (Please send copy of insurance card)

Primary Insurance Company

_____

Insurance Member ID Number | Insurance Group Name or Number

_____ | _____

Subscriber Name | Subscriber Date of Birth | Relationship to Patient

_____ | _____ | _____

Secondary Insurance Name (if applicable)

_____

Secondary Insurance Member ID | Secondary Insurance Group Number

_____ | _____

Secondary Insurance Subscriber Name | Subscriber DOB | Relationship to Patient

_____ | _____ | _____

5. Insurance Card: Please fax or securely email a copy or photo, both FRONT and BACK, of the patients's insurance card.

6. Additional Information: Please fax any additional information pertinent to behavioral health.