PATIENT REFERRAL

Julie Rubin McGaughey, L.P.C.
117 Oglethorpe Professional Ct.
Unit 1
Savannah, GA 31406

Phone 912/658-8169 ▪ Fax 678/658-9029
www.atlanticcoastaltherapy.com

P L E A S E F A X C O M P L E T E D F O R M S T O 6 7 8 / 6 5 8 - 9 0 2 9

PATIENT INFORMATION

Name____ DOB_____/_____/_________
(first, middle, last)

Address ____

City____________________________State___________________ZIP ____________________

Parent/Guardian ____

Patient's Daytime Phone ( ) __________________ Patient's Mobile Phone ( )____________________

Patient's Email Address ___________________________

PRIMARY INSURANCE ____

Policy Holder's Name _________________________________

Policy # ____________________________________

SECONDARY INSURANCE ____

Policy Holder's Name _________________________________

Policy # ____________________________________

REFERRING PHYSICIAN INFORMATION

Name_______________________________Referring Provider's NPI _________________________

Address____________________________Phone ( ) ________________________

City________________State_______ZIP_________Fax ( ) ________________________

Name of Contact Person ____

REASON FOR REFERRAL ____

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Thank you for your kind referral. I appreciate the opportunity to provide service to your patient.

INTEROFFICE USE: Date of Appointment_______________Time__________AM/PM

Scheduled by__________________________Date Scheduled __________________

Referring notified of appointment? ▢ Yes ▢ No By ______________________________