Faith G. Harper, PhD, LPC-S
A Healing Alternative Counseling and Wellness Center, LLC
info@faithgharper.com www.faithgharper.com
Phone: (210)705-2121 Fax: (210) 568-4816

Referral Form

Name:____________________________________ Preferred Name (if different):____________________________________
Address:____ City:_________________________ State:______
Zip:_________ Phone:_______________________ Cell Phone:_______________________Fax:__________________________
DOB:_______________________ Gender: __M ___F ___Other Email address: _____________________________________

Preferred Form of Contact? ___Phone _____Cell Phone _____Text ____Email

If Phone Contact checked, OK to leave message?_____

If you marked that you prefer email contact or text contact, please note the following: I understand that the confidentiality of information transmitted via email or text cannot be guaranteed. ___________ Your Initials

Referring Provider

Name:____
Provider Type/Licensure:____
Address:____ City:________________________ State:______
Zip:_____________Phone:_____________________________________Fax:____

Reason For Referral:____
____
____

Diagnoses (if applicable):____
____
____

Current Medications (including vitamins and over the counter medications):____
____

I authorize the above referring provider to submit the following referral to Faith G. Harper along with any pertinent records to assist her provision of evaluation, assessment, and treatment. I authorize Faith G. Harper or her designee to contact me by my noted preferred contact method to schedule an appointment. I understand that this referral does not commit me to services with Dr. Harper.

______________________________________ ______________________________________ _____________
Printed Name Signature Date

If I am receiving ongoing therapy services from another licensed therapist, and receiving specialty services from Dr. Harper, it is required by her Code of Ethics to remain in contact with the primary therapy provider during the course of treatment. I understand this and have completed a consent to release information to and from this provider.

______________________________________ ______________________________________ _____________
Printed Name Signature Date

I understand that if I am continuing to receive services from another treatment provider (i.e., a medical provider), it may be necessary for Dr. Harper to consult regarding her treatment in order to facilitate appropriate continuity of care. I have discussed this with the referring provider and have completed a consent to release information in this regard, if we have agreed this is necessary.

______________________________________ ______________________________________ _____________
Printed Name Signature Date