RIA
Behavioral Health Ltd.

Name of the referred individual ***DOB*** .
Email address_____.

Mobile _____ Home _____.

Address_____.

(If referred less than 18 yr old)

Parent/ Guardian name

Address(if different than the referred person) _____.
. Contact No (mobile) _____ home _____.

Insurance information;

The reason for referral ;

Does this referred person in case of urgent mental health issues Yes ☐ No ☐ .
Referrer's full name _____.Contact No_____.
address _____.
Referrer's relationship to the referred individual: Family Member/Friend ☐ ;Healthcare provider ☐ Patient ☐ ,

Medical HX_____ **Allergies** _____.

Medications _____ **:**

Scope of Services at RIA

I understand that RIA Behavioral Health provides outpatient mental health care services only and does not offer crisis or emergency care. In the event of a medical or psychiatric emergency, I will call 911 or go to the nearest emergency room.

Confidentiality and Privacy (HIPAA Acknowledgment) RIA

I understand that all information shared with RIA will be kept confidential and protected under HIPAA regulations, with certain legal exceptions, including but not limited to:

- **Threats of harm to self or others. Suspected abuse or neglect of a child, elder, or vulnerable adult. Court-ordered disclosure of medical records**

Parental Responsibility I agree to provide accurate and complete information about my child's health and history. I am responsible for ensuring my child attends scheduled appointments and adheres to the treatment plan discussed with the provider.

Appointment Cancellations and Missed Appointments I agree to provide at least 24 hours' notice for appointment cancellations. I understand that failure to do so may result in a cancellation fee.

Non-Guarantee of Outcomes I understand that mental health care is a collaborative process, and RIA does not guarantee specific outcomes. Treatment effectiveness depends on my child's engagement and other factors beyond the clinician's control

Consent and acknowledgement

- I have read, understood, and agree to the terms outlined above. I consent to my child (if referred person less than 14 yr of age) receiving outpatient psychiatric services from RIA, which may include evaluations, therapy, and medication management as deemed necessary by the treating clinician.
  Guardian/ Parent _____.

- I have read, understood, and agree to the terms outlined above. I consent to receiving outpatient psychiatric services from RIA , which may include evaluations, therapy, and medication management as deemed necessary by the treating clinician. Referred person signature _____ .

Signature of Parent/Guardian/ Patient _____.

Name of Guardian/ Patient _____.

Signature of Witness/ Referring Provider _____.

Name of Referring Provider _____.

Date

Kindly Fax this form at 920-843-9162.

Attach the following forms-

1- **release of information**
2- **copy of insurance/ unless self-pay**
3- **laboratory test results in past 1 year**
4- **medication list**