Referral Date: _____

Referral from: _____

The Family Collective Counseling Referral Form

Through Insight Counseling, The Family Collective offers free, trauma-informed counseling for families that are receiving services through any partner organization of The Family Collective. Counseling is available to individuals, couples or families.

Please fill out contact information for the head of the household who is seeking counseling. Please email this form to Intake@insightcenters.org. After Insight Counseling receives the form, the client will need to call their Intake line to set up therapy: 615-383-2115, ext. 100. They need to reference The Family Collective when calling.

Last Name:		**First Name:**	
Cellphone:		**Other Phone:**	
Email:		**Interested in Telehealth Sessions:** Yes ☐ No ☐	
Current Address:		**Shelter:** ☐ **In car:** ☐ **Friend / Relative:** ☐ **Motel:** ☐ **Own:** ☐ **Rent:** ☐	
Household Composition: *(Name, age and relation to head of household)*		**Client's ASSM Score:** _____ *Please fax or email the full ASSM assessment along with Referral Form and Release of Information Form.*	
Family's External I.D. Number: *(Located in Salesforce)*			

Why are you seeking counseling at this time?

Who are you seeking counseling for (self, whole family, child, etc.)?

Rate severity of current problems on a scale from 1 to 5
(1 being the least severe and 5 being more severe).

Rate severity of family stress on a scale from 1 to 5
(1 being the least severe and 5 being more severe).

What do you hope to gain from mental health counseling?

Is there anything else you want us to know?

Please email this form to Intake@insightcenters.org.

After Insight Counseling receives the form, the client will need to call their Intake line to set up therapy: 615-383-2115, ext. 100. They need to reference The Family Collective when calling.

Insight Counseling Centers · Siemer Institute · TN Department of Human Services · The Family Collective · United Way of Greater Nashville

Insight COUNSELING CENTERS

AUTHORIZATION FOR RELEASE OF INFORMATION

Re: Name: _____ Date of Birth: _____

Address: _____
Street City / State Zip

I hereby authorize _____
(Name of agency or individual)

_____
(Address, City, State, Zip Code)

and its physicians, employees and agents to release or disclose to/from _____ with

Insight Counseling, 678 Brook Hollow Road, Nashville, TN 37205
(Address, City, State, Zip Code)

all of my medical records including any specifically protected, such as those relating to psychological impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection. Documents authorized for disclosure include:
(Initial approved items)

_____ (1) Medical history, examination, laboratory tests and treatment reports
_____ (2) Psychological test reports
_____ (3) Psychiatric evaluation reports
_____ (4) Social history data including family, education, employment and other relevant material
_____ (5) Summary of previous mental health and/or counseling services
_____ (6) Periodic reports of current treatment progress including attendance and participation
_____ (7) Notification of referral source of initiation and termination of counseling
_____ (8) Specify: _____

I understand that this information will be used for the following specific purposes:
(Check ALL items)

YES	NO	
☐	☐	(1) To develop an assessment, counseling, casework, and/or adoption plan
☐	☐	(2) To coordinate medical, psychological and social rehabilitative processes
☐	☐	(3) Specify: _____

I understand no information may be re-disclosed by either agency to any other individual or agency unless by my written consent. I therefore authorize the release/disclosure of the following documents *(Initial approved items)*:

_____ 1. Only records generated by the above-named provider (not including records received from other sources).
_____ 2. Only a portion of the records maintained by the above-named provider (dates of treatment, etc.)
Please specify: _____
_____ 3. All records at this facility.

You may revoke this consent to release personal, educational and protected health information at any time, by written request. Unless you revoke it, this authorization shall remain in effect for one year or until such time as specified herein:
_____

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your protected health information and no longer by the HIPAA Privacy Rule. This consent for release of information is given freely, voluntarily, and without coercion.

_____
Signature of Client Date Signature of Case Manager Date

_____
Signature of Responsible Party for Minor Relationship