



Nancy Evans LCSW, CSOTP
 5445 Main Street
 Stephens City, VA 22655
 (540) 869-2008 Office/Fax
Brushdanceclinic@aol.com

CLIENT REFERRAL FORM

NAME: _____

DATE OF BIRTH: ___/___/___ SS# _____

ADDRESS: _____

TELEPHONE: (H) _____ (C) _____

PARENTS/GUARDIAN NAME(S): _____

SERVICES START: _____ SERVICES END: _____
 (projected)

1. Turning Leaf Services:	before Jan 1, 2012	after Jan 1, 2012
Psychosexual/Juvenile Sex Offender Evaluation	_____ \$650	\$800
Individual Outpatient /Juvenile Sex Offender Specific	_____ \$100/hr.	\$125
Family outpatient: JSO Specific	_____ \$100/hr.	\$125
Parent Support Group (weekly)	_____ FREE	Free
2. Parenting Group:		
Parenting Programs	_____ \$500	\$600
	for 8 weeks	(family unit)

Net authorized billings: _____

Authorized Representative: _____ Date: _____

Brush Dance Clinic representative: indicate acceptance or refusal and return to authorized representative:

- _____ I hereby agree to provide the service requested.
- _____ I hereby refuse to provide the service requested.

I agree billing will be submitted no later than 15 days of the close of the month.

Brush Dance Clinic Representative: _____ Date: ___/___/___