

Counseling Center of Montgomery County

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(936)760-1880 Offc
(936)760-9101 Fax

REFERRAL AND CONSENT TO RELEASE INFORMATION

From: _____

To: Counseling Center of Montgomery County

Name of Client(s):		Gender: Male Female	
Address:			
City:		State / Zip:	
Cell Phone:	Home Phone:	Work Phone:	
Email Address:		Date of Birth:	Age:
Social Security #:		Medicaid#:	
Caseworker:			
Email Address:		Phone Number:	

***If referring multiple members of the family, please complete a form for each family member.**

Requested Services:

Group Therapy	
*Certificate of Completion available upon request	
Substance Recovery	<input type="checkbox"/>
Alcohol Recovery	<input type="checkbox"/>
Anger Management	<input type="checkbox"/>
Conflict Resolution	<input type="checkbox"/>
Coping Skills	<input type="checkbox"/>
Healthy Relationships	<input type="checkbox"/>
Divorce Recovery (Adults / Teens / Kids)	<input type="checkbox"/>
Parent Class for Divorcing families	<input type="checkbox"/>
Extended Parent Class for Divorcing Families	<input type="checkbox"/>
Productive Parenting Classes	<input type="checkbox"/>
Extended Productive Parenting Classes	<input type="checkbox"/>
Blending Your Family	<input type="checkbox"/>

(please check all that apply)

Assessments	
Substance / Alcohol Abuse	<input type="checkbox"/>
Anger Management	<input type="checkbox"/>
Diagnostic Review	<input type="checkbox"/>
Mental Health Evaluation	<input type="checkbox"/>
Other:	<input type="checkbox"/>
Counseling Services	
Individual Counseling	<input type="checkbox"/>
Group Counseling	<input type="checkbox"/>
Family Counseling	<input type="checkbox"/>
CoParent Counseling	<input type="checkbox"/>
Other:	<input type="checkbox"/>

I authorize the Counseling Center of Montgomery County and my Caseworker to exchange my information and release my entire record throughout my treatment.

Client Signature

Printed Name

Date

Caseworker

Printed Name

Date

*Most insurances accepted, but some fees may apply