



201 N. Ballard Ave. Ste 104  
Wylie, TX, 75098  
Office: (972) 442-5300 Fax: (469) 480.5444

## Behavior Health Service

Dear Administrator:

We are pleased to announce that HB Family Services is now accepting new clients for our remote behavioral health services. We specialize in providing accessible, high-quality mental health care via telehealth to clients across the DFW Metroplex and surrounding areas.

Enclosed you will find our referral form. We welcome referrals for individuals who may benefit from compassionate, evidence-based support for a wide range of mental health needs. Our services are designed to meet clients where they are—conveniently and confidentially.

If you have any questions regarding scheduling, insurance verification, or language support, please don't hesitate to call our office. A member of our team will be happy to assist you and ensure a smooth referral process.

We look forward to collaborating closely with your agency and supporting the well-being of your clients.

We currently accept the following insurance plans:

- ❖ Aetna-All Plans
- ❖ BCBS-(TX and most other plans)
- ❖ Cigna
- ❖ Magellan
- ❖ Texas Medicaid
- ❖ Superior/Centene
- ❖ Tricare
- ❖ United Health Care-All Plans



Please contact us about any plans not listed above.

Let HB Family Services be your trusted partner in behavioral health care.

Warm regards,

A handwritten signature in black ink, appearing to read 'Torshia Watson', written in a cursive style.

Torshia Watson, LPC, CEO  
Licensed Professional Counselor  
Serving the DFW Metroplex with compassionate care for over 20 years



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# Homebound Family Services

## Referral Form

### Patient Information:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Marital Status: \_\_\_\_\_ SS#: \_\_\_\_\_ Gender: Male / Female

### Emergency Contact Information:

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Reason: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Insurance Information:

Medicare ID: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Other Insurance: \_\_\_\_\_

### Home Health Agency Information:

Agency Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Pertinent Health Information:

Diagnoses: \_\_\_\_\_

Current Treatment: \_\_\_\_\_

### Reason for Referral (please check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Grief and Loss   | <input type="checkbox"/> Substance Use / Co-occurring |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> OCD                          |
| <input type="checkbox"/> ADHD             | <input type="checkbox"/> Impulsivity                  |
| <input type="checkbox"/> Trauma / PTSD    | <input type="checkbox"/> Other                        |

\*\*\*Please attach most assessments, diagnosis or therapy notes\*\*\*