535 SE Washington Street
Hillsboro, OR 97123
Phone: 503-755-6703
Fax: 503-755-6704
Email: visionary@vpteam.hush.com

NEW PATIENT FORM

Date of Reference: _____ **Referral Urgent:** ☐ Yes ☐ No

Patient Name: _____ **Date of Birth**: _____

Sex: ☐ Male ☐ Female **Gender:**_____ **Preferred pronoun/name if app.**_____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Phone number: _____ **Email:** _____

Parent/Guardian if app.: _____

Insurance: _____ **Member ID**: _____

☐ **Commercial** ☐ **Medicare**

The intake process takes 7 business days, if you have not heard from our scheduling team in that time frame, please alert us at visionary@vpteam.hush.com

Relevant Medical History and Background Info:

Reason for Referral: _____

Diagnoses: _____
Additional Comments: _____
_____

Patient and/or POA/Caregiver is aware and consents to Referral: Yes No

☐ I give Visionary Psychiatry / VP, permission to build me in their system as a patient in RxNT, for insurance verification of benefit eligibility check, and for future scheduling outreach.

☐ By checking this box you agree to receive recurring messages from Visionary Psychiatry. Reply STOP to Opt-out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages.