



535 SE Washington Street
Hillsboro, OR 97123
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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.

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VISIONARY PSYCHIATRY

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