



535 SE Washington Street Hillsboro, OR 97123

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NEW PATIENT FORM

Date of Referral: _____

Referral Urgent: Yes No

Patient Name: _____

Date of Birth: _____

Male Female Prefer not to disclose

Preferred name (if applicable): _____

Address : _____

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

Phone number : _____ Email: _____

Parent/Guardian (if applicable): _____

Insurance : _____ Member ID: _____

Commercial

Medicare

Medicaid

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 authorize Visionary Psychiatry (VP) to add me to their system as a patient in RxNT for insurance verification of benefit eligibility and future scheduling outreach.

I do not wish to proceed with the referral.

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VISIONARY PSYCHIATRY

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