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 ☐ **N**o

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 elegibility check, and for future scheduling outreach.

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