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 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): _____

Emergency contact name: _____

Emergency contact's relationship: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Emergency contact's phone number: _____

Insurance: _____ Member ID: _____

☐ Commercial ☐ Medicare ☐ Medicaid / OHP

The intake process takes up to 3 business days. If you have not heard from our scheduling team in that time, please alert us at visionary@vpteam.hush.com or call 503-755-6703.

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 Athelas, VP's electronic health record, for insurance verification of benefit eligibility and future scheduling outreach.

☐ I do not wish to proceed with the referral.

Signature

_____ Date: _____

Signature of patient, parent, guardian, or POA

Printed name: _____ Relationship to patient: _____

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