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NEW PATIENT INTAKE FORM

TODAY'S DATE: _____

APPOINTEMENT DATE: _____ TIME: _____

PATIENT INFORMATION

Patient Name: _____ Email Address: _____ DOB:_____

Home#:_____ Mobile#: _____ Work#:_____ Pharmacy#:_____

Home Address:_____

If Minor, Name of Parent/Guardian:_____

Guardianship or Marital Status:_____

Prior or Present Drug/Alcohol Abuse: _____

Referred By:_____

Purpose of Visit:_____

Medication/s:_____

Initial Fee **$700** _____ (INITIALS)

Aware of a **$200** deposit which is refundable within 24 hours if appointment is cancelled _____ (INITIALS)

Follow Up Fee for both in office or telehealth appointments is **$295,** appointments for 45 minutes is **$550,**
Forensic Psychiatry Fee is $900 _____ (INITIALS)

Aware of FULL FEE in the event the patient Did Not Keep Appointment; MUST provide 24-hour notice of cancellation to avoid fee. _____ (INITIALS)

ALL NEW PATIENTS COME AT LEAST 10 MINUTES EARLY TO FILL OUT PAPERWORK or EMAIL PAPERWORK
We will make every effort to schedule late afternoon appointments for our school-aged children and working adults. There may be times that we will be unable to fit all our patients in mid/late afternoon slots. Please be awate of this and be prepared to take them out of school or leave work early on occasion.

CREDIT CARD INFO

CARDHOLDER NAME: _____

CARD TYPE: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

CARD #: _____ EXP DATE: _____ CVC: _____ ZIP: _____