



## New Patient Referral Form

You may fax to 678-335-2477 or email to [info@int-psy.com](mailto:info@int-psy.com).

### **Patient Demographics:**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile Phone (Main): \_\_\_\_\_ Alt Phone: \_\_\_\_\_

### **Insurance (Primary):**

Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber/ID Number: \_\_\_\_\_ Group#: \_\_\_\_\_

### **Referring Provider:**

Name of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Organization: \_\_\_\_\_ Fax: \_\_\_\_\_

### **Reason for referral (Diagnosis, Current Medications, other relevant information)**

---

---

---

---

- Please attach any relevant notes, labs, testing or records.
- Per our office policy we charge a \$50 no show/late cancellation fee (defined as appointment not cancelled prior to 48 hours) for existing patients and \$100 no show/late cancellation fee for new patients.