Appointment Request Form

Instructions: Please fill out form completely and email/fax to the requested office and we will contact you to schedule the appointment.

Patient Information

Name:	DOB:	Sex: ☐ Male ☐ Female
Address:	City:	State: Zip:
Parent Name:		
Phone Number: ◉ Cell/Home ○	Email:	
How did you hear about us: ☐ Physician: _____ ☐ Family ☐ Friend ☐ Internet/Google ☐ Other: _____		
Has the patient been professionally diagnosed with any of the following? ☐ None ☐ ADHD ☐ Anxiety ☐ Depression ☐ Autism/Asperger's ☐ Learning Disability/Developmental Delay ☐ Mood Disorders ☐ Bipolar ☐ Schizophrenia ☐ Psychosis ☐ Suicidal ☐ Alcohol/Drug Dependency ☐ Other: _____		
List any medications taken for conditions listed above: _____		

Insurance Information

Insurance Name:	Phone Number:
Policy/Member Number:	Group Number:
Policy Holder:	DOB:

Appointment Request

☐ **Morning** ☐ **Afternoon**	**Specific Dates Requested (if any):**	
☐ **Charlotte Office - Fax: (980) 636-6518**	☐ **Greensboro Office - Fax: (336) 398-5665**	
Charlotte Physician Preference:	☐ **Dr. Perry Roy**	☐ **Alyssa Sullins, PA**
Greensboro Physician Preference:	☐ **Dr. Amy Stevenson**	☐ **Dr. Emily Thompson**

Notes/Special Instructions or Questions

For Office Use Only

Completed By:	Scheduled with:	Appointment Date:	Appointment Time:
Insurance Benefits			
Effective Date:	Benefit Period:	Rep Name/Website:	Date/Time:
Deductible: $	Deductible Met: $	Coverage: /	Copay: $
96120/96119 Coverage:		Precert/Auth Required: Yes / No	
Notes:			