Ivy Collaborative Healthcare | PRIVIA MEDICAL GROUP

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New Patient Referral Form

Patient Demographics:

Legal Name (First, Middle, Last, Suffix): ____

Date of Birth: ______________________________ Sex: ___________________________

Address: ____

City: ___________________________________ State: __________ Zip Code: ___________

Mobile phone: ____________________________ Alt Phone: _______________________

Primary Email: ____

Primary Insurance:

Company Name: ____

Member ID #: _____________________________ Group #: ___________________________

Address (may be PO Box): ____

Policy Holder Name: _______________________ Relationship: _____________________

Referring Provider:

Name of Facility: ____

Name of Provider: ______________________________ Phone: _______________________

Please list or send documentation of reason for referral, diagnosis, current AND historical medications, other relevant information:____

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- ✓ Please attach any relevant records, progress nots, lab results, testing that you deem will be helpful in assessing the patient's needs.
- ✓ Please advise the patient that they will be charged $100.00 Appointment hold fee that will be applied to their future co-pays, deductibles, or co-insurance until the holding fee is fully allocated.
- ✓ Please advise the patient that there is a $100 No Show/Late Cancellation fee for new patients and a $50 No Show/ Late Cancellation fee for established patients.