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:_____
_____
_____
_____
_____

- ✓ 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.