THE RETREAT AT PONTE VEDRA BEACH

PEDIATRIC PSYCHIATRIC REFERRAL FORM

Office:	The Retreat at Ponte Vedra Beach, 35 Executive Way, Suite 104, Ponte Vedra Beach, FL 32082		
	Phone: (904) 335-3252	Fax:	(904) 562-3395

Thank you for choosing to refer your patient to The Retreat at Ponte Vedra Beach.
Please include any relevant medical records or test results that support this referral.

Date:	No. of pages:
Referring MD/Provider: Practice Name:	Fax From:
Referring MD/Provider Phone: Referring MD/Provider Fax:	Fax to:

Requesting Transfer for subspecialty care **or** 1-3 visit collaboration of care consultation only?

Routine or Urgent Request?

BILLING: We are considered out of network for all insurance policies. We do not submit claims. Payment in full is required at the time of the service. A Superbill will be issued which the patient may choose to submit to their insurance company for possible reimbursement/partial reimbursement at an out of network rate per their insurance policy.

______ The patient is aware payment is due at the time of service at The Retreat at Ponte Vedra Beach and agrees with the referral.

Please refer to office policies at http://www.retreatpvb.com/office-policies/ for details.

NOTICE OF CONFIDENTIALITY:

This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein. Please notify us at 904-335-3252 with any concerns.

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Referral Information Page		
Patient Name:	DOB:	SSN# Optional:
Home Phone:	Cell:	E-Mail:
Address:		
Mother's Name and Contact:		
Father's Name and Contact:		
Primary Psychiatric Diagnosis:	Secondary Psychiatric Diagnosis:	
Referring Concern(s):		
Current Medications:		
Medical Diagnoses:		

REFERRING PHYSICIAN/PROVIDER SIGNATURE: ____

DATE:____

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