KATE BLUMNER MD, LLC

1600 SE Bybee Blvd, Suite 200, Portland, OR 97202 • tel: 971-229-0269 • fax: 971-229-0617

New Patient Information

Demographics:

Name: *Date:*

Date of Birth: ☐*Cell#:*

☐*Home#:* ☐*Work#:*

[Check box if ok to leave messages]

Physical/Mailing Address:

Email:

Current job or employer:

Emergency Contact:

Name: *Phone #:*

Relationship to you:

Medical Information:

Primary Care Provider:

Phone: *Address:*

Preferred Pharmacy: *Phone:*

List any current medications & doses (if any):

Medication Reactions/allergies: ☐*no medication allergies*

Current or past medical problems:

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Mental Health Information:

Briefly describe reason for seeking care:

Please describe any previous mental health care:

Have you ever been hospitalized psychiatrically? ☐*yes* ☐*no*

If yes, please list dates/locations:

Past psychiatric medications (if applicable):

Family History: (Please describe any mental health or substance use problems in family members)

Please list any other mental health providers that you currently see:

Name: *Phone:*

Name: *Phone:*

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Insurance Information

Primary Insurance Company:

Member ID: *Group#:*

Phone:

Insured's Name (if different from yours): *DOB:*

Secondary Insurance (if applicable):

Member ID: *Group#:*

Insured's Name (if different from yours): *DOB:*

Phone:

Authorization to Release Information and Assignment of Insurance Benefits

I hereby authorize Kate Blumner, MD to:

1. Furnish my insurance company with any/all information requested concerning my present claim(s), including my records if requested
2. Bill my insurance company, and to accept payment from the company on my behalf, for all services related to my care.

I acknowledge that I am responsible for all charges not covered by my insurance. I understand that I become responsible for any charges not paid by my insurance after 90 days. I understand that any money received from me by Kate Blumner, MD, in excess of my bill will be refunded to me after completion of treatment. I also understand that I will be charged for any appointment that I fail to keep or cancel within 48 hours prior to that appointment time and I agree to pay those charges in full. See financial policy sheet for complete information regarding your account.

Signature: *Date:*