Erik Morris PMHNP LLC

9900 SW Greenburg Rd.
Suite 205
Tigard, OR 97223
Phone: (503) 206-5578 | **Fax:** (503) 935-5884

E-mail: SamadhiPsychiatric@pm.me

Medical Assistant, Annelliese Alburas: This number is great for texting 503-446-9863

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Preferred Name: _____ Gender: _____ Preferred Pronouns: _____

Home #: _____ Cell#: _____

Email Address: _____ May we use Email to send messages? _____

We use email for appointment reminders so it may not be confidential.

Employer: _____ Work #: _____

Responsible Party: _____ Relationship: ☐Self ☐Spouse ☐ Other _____

Address: _____ Contact #: _____

Primary Insurance: _____ Subscriber: _____

ID#: _____ Group#: _____

Secondary Insurance: _____ Subscriber: _____

ID#: _____ Group#: _____

We need to obtain a copy of your insurance card. Please call the office to arrange this request. You can send it by email, 'snail mail,' fax, or even text/picture message.

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- ___I understand that I am responsible for payment of services.
- ___I authorize the release of any health information necessary to process insurance claims for services. This release of information expires when I close services
- ___I authorize my insurance company to pay medical benefits to the provider of services. I understand that I am fully responsible for all professional fees not covered by this assignment.
- ___I was offered a copy of the HIPAA notice and Office Policies.
- ___Unless paid for by check or cash at the beginning of an appointment, I authorize the use of my credit or debit card to pay the balance of my fees.
- ___I understand that payment is due at the time of service unless prohibited by the provider's contract with insurer.

Patient Signature: _____ Date: _____

If required: Parent/Guardian or Patient Representative:

Printed Name: _____ Relationship: _____

Signature: _____