Shelly Riley, M.D.
2224 Walsh Tarlton Lane, Suite 110
Austin, TX 78746
512-291-6086
www.shellyrileymd.com

New Patient Requests for Dr. Riley
Child and Adolescent

Date:_______________

Name of person requesting a new patient appointment
(i.e, who is filling out this form?) :______________________________________

Name of potential patient:____

What is your relationship with the patient?_________________________________

Age of potential patient __________

Who referred you?____

Brief Explanation for Reason for Referral:_________________________________
____

Would you like to use insurance?__________

If so, what insurance would you like to use?_______________________________

Do you have UHC or UBH?_____________

Does the potential patient have Medicare or Medicaid?________________

Do you have a secure email or fax that we could use to contact you?_______________

If so, please provide that information:_______________________________________

If parents are separated or divorced, will the parent attending the appointment have full medical decision-making responsibility?_____________________________________

Who has medical decision making responsibility?______________________________

Do you expect any issues with regard to parents coming to an agreement regarding the use of medications? If so, please explain
____

New Patient Requests for Dr. Riley:

Dr. Riley provides consultation and therapy regarding the use of psychotropic medication. She does not provide weekly psychotherapy.

Dr. Riley is out of network for insurance plans. You will be given a detailed receipt to send into your insurance company after full payment is made at time of visit. Current fees are as follows:

Initial Evaluation - $400.00 (1 hour)
Follow up Appointments: $165.00 (20 minute)
Follow up Appointments: $200.00 (30 minute)
Follow up Appointments: $300.00 (45 minute)

You will be contacted after we review the information you provide.

To secure your appointment time and date, we require a Visa or MasterCard number. If you need to cancel or move your patient appointment we require two business days notice to do so. Please keep in mind that you will be charged $400.00 if you do not give us the notice we require. Thank you for your understanding. We will obtain your card number at the time we book your appointment.

Thank you for your interest in Dr. Riley's practice.

You may fax or email this information to Tracie at: Fax – 512-291-6507 or email: admin@shellyrileymd.com

---

Shelly L. Riley, M.D.
2224 Walsh Talrlton Lane, Suite 110, Austin, TX 78746

Patient Information:
Name:____
Address:____
Phone Number:____
Date of Birth:________________________________ Age_____________

Mother Information: **LEGAL CUSTODY: YES NO**
Name:____
Address:____
Phone Number:____
Work Number:____
Email:____

Father Information: **LEGAL CUSTODY: YES NO**
Name:____
Address:____
Phone Number:____________________________________
Work Number:_____________________________________
Email:____

Alternate Caregiver: **LEGAL CUSTODY: YES NO**
Name:____
Relationship:____
Address:____
Phone Number:____
Work Number:____
Email:____

Name:___________________________________

Birth Date: _____/_____/_____

Age:______

Gender: Male Female

Address (Street and Number):___________________________________

City: __________________ State: ___________________ Zip: ______________

Home Phone: (_____) _____-________

May We Leave a Message Yes No Cell/Other Phone: (_____) _____-________

May We Leave a Message Yes No E-mail: May We Email You? Yes No *Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation: Place of Employment:___________________________________

Work Number: (_____) _____-________ If needed, is it OK to call here? Yes No

Emergency Contact: Name:___________________________________

Relationship:___________________________________

Phone Number: (_____) _____-________