

# Contact Information Form

*(Screening services are not reimbursable through insurance or EAP programs.)*

Date \_\_\_\_\_

Your Name \_\_\_\_\_ DOB \_\_\_\_\_

Marital Status \_\_\_\_\_

Age \_\_\_\_\_ Telephone (mob) \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_

Name of Spouse/Partner/Significant Other \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Telephone (mob) \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_

Home Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

*Dr. Pierce-Davis has informed me that Screenings for medical procedures are not reimbursable through insurance companies.*

Signature \_\_\_\_\_

Signature \_\_\_\_\_

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Physician who referred you \_\_\_\_\_

Medical Group/Address \_\_\_\_\_

Nurse Coordinator/email contact \_\_\_\_\_

Anticipated Procedure \_\_\_\_\_

Agency (if applicable) \_\_\_\_\_

Agency Contact Person (if applicable) \_\_\_\_\_

**Carol Pierce-Davis,  
Ph.D.  
Psychologist**

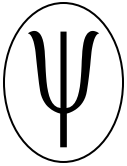
**National Register of  
Health Service Providers**

**Texas Health Service  
Provider**

**Board Certified  
Diplomate Fellow  
Psychopharmacology**

**Board Certified  
Diplomate Fellow  
Serious Mental Illness**

**Board Certified  
Medical Psychologist**



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