REFERRAL FORM FOR PSYCHOLOGICAL SERVICES

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MANDATORY DOCUMENTS TO SEND TO COMPLETE REFERRAL PROCESS:

- ☐ This completed form along with:
- ☐ Pt. demographics & insurance (face sheet)
- ☐ **Copy of insurance card (mandatory)**
- ☐ Most recent doctor's chart note
- ☐ Our New Patient Questionnaire (8 pages)

I am referring the following patient:

Name: _____DOB:_____

Phone Number: (_____) _____

for psychological service as checked below:

CHECK BELOW: **Psychological Clearance for :**

IMPLANTABLES

- ☐ **Spinal Cord Stimulator (SCS)**
- ☐ **Intrathecal Pain Pump**
- ☐ **Dorsal Root Ganglion Stimulator (DRG)**
- ☐ **Peripheral Nerve Stimulator (PNS)**

- ☐ **INTERVERTEBRAL RADIOFREQUENCY ABLATION BASIVERTEBRAL NERVE**

_____

Referring Physician: _____ **NPI:**_____

Address: _____ **Phone:** _____

_____ **Fax:** _____

_____

CONTACT PERSON: _____
(please provide OFFICE STAFF CONTACT PERSON)

EMAIL: _____
(Fax is where reports go to die. Please provide contact email for most effective communication)

UPDATED 04-30-2025

TIMOTHY L. SAMS, PH.D.
PACE, INC

Phone 760-404-0183 CA 208-255-4846 ID; Fax 714-526-1602; Email scsdrsams@gmail.com

PATIENT INFORMATION AND FEE AGREEMENT

***** YOU MUST FILL OUT ALL OF THE REQUESTED INFORMATION & SIGN*****

Patient Name: _____ DOB:_____ Age: ____ Sex: (M) (F)
(Last, First, Middle Initial)

Address: _____
Number Street City State Zip

Preferred phone: ( )_____Email Address: _____

Referred by Dr.:_____Phone: ( ) _____

YOU MUST COMPLETE THE REQUESTED INFORMATION LEGIBLY AND IN FULL INCLUDING YOUR NAME AS IT APPEARS ON YOUR MEDICARE CARD. WE WILL BILL YOUR MENTAL HEALTH INSURANCE BASED SOLELY ON THE INFORMATION YOU LIST BELOW. WE WILL NOT USE INFORMATION FROM THE REFERRING OFFICE OR AN ATTACHED INSURANCE CARD. WE ACCEPT MEDICARE, BUT NO OTHER INSURANCE. CASH PATIENTS WILL PAY $195 AS PAYMENT IN FULL AT THE TIME OF YOUR APPOINTMENT BY CREDIT OR DEBIT CARD. REGULAR MEDICARE COVERS MENTAL HEALTH SERVICES, BUT ANY MEDICARE REPLACEMENT PLAN LIKE UHC, SCAN, HUMANA, OR IEHP, ETC., WILL NOT COVER OUR SERVICES.

EVERYONE NEEDS TO COMPLETE INSURANCE INFORMATION IN FULL

MEDICARE NAME: _____

Insured Member Name from your Medicare Card:_____DOB: _____

NAME OF SECONDARY MENTAL HEALTH INSURANCE: _____

Insured Member Name from your insurance card:_____DOB: _____

Insured Member ID#:_____Policy/Group#_____

The above information is true to the best of my knowledge. I authorize my Medicare insurance benefits to be paid directly to PACE, Inc unless I pay by debit or credit card in full at the time of the appointment. I fully understand that I am the responsible party for all charges incurred by me at this practice. **I am solely responsible for verifying my insurance coverage and I know that neither Dr. Sams' office nor the referring doctor has verified my insurance coverage. The initial consultation and assessment fees include the following services: clinical interview, review of available records, several hours of psychological testing, mental status evaluation, determination of clearance, patient education, and report writing, which is paid at the highest level of medical complexity. I** authorize PACE, Inc to release 1) all information necessary to secure payment; and 2) any relevant information to the referring physician. If my interview is through telemedicine, I consent to the use of that modality and understand that that are greater risks to confidentiality. For telecommunication assessments, Dr. Sams will be alone during the interview and I will have no more than one support person in the room with me. My interview will not be recorded or stored electronically. By signing this form, I acknowledge all of the above.

Patient Signature: _____ *Date:* _____