

**Assured Hope Community Health, LLC**

**7 TECHNOLOGY DRIVE SUITE 201 CHELMSFORD MA, 01826**

**Tel: 978-677-6354. Fax: 978-677-6456**

**Email: [ahch@assuredhopehealth.com](mailto:ahch@assuredhopehealth.com)**

**New Patient Appointment Request Form**

Complete all information on this form and email to [ahch@assuredhopehealth.com](mailto:ahch@assuredhopehealth.com).

Services Needed  Medication Management  Psychotherapy/counselling/Duo Diagnosis

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

DOB \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Email: \_\_\_\_\_

Name of Insurance \_\_\_\_\_ ID# \_\_\_\_\_

CHECK BACK OF INS CARD

If your card states mental health services, go thru another company please list that here:

\_\_\_\_\_. Alt ID # \_\_\_\_\_ Copay \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referred By \_\_\_\_\_

Why are you seeking help? \_\_\_\_\_

\_\_\_\_\_

Past inpatient hospitalizations in the last 6 months-1 yr (Diagnosis & treatments). \_\_\_\_\_

\_\_\_\_\_

Past outpatient services and Providers 6 months-1yr (Diagnosis, Treatment) \_\_\_\_\_

Current Psychotropic Medications \_\_\_\_\_

\_\_\_\_\_

Substance Use/Abuse issue \_\_\_\_\_

Current Controlled Substance use \_\_\_\_\_

\_\_\_\_\_