Blue Umbrella
Comprehensive Psychiatric Care

Appointment Request Form

Let us know how we can help you!

Patient's Full Name *

First Name Last Name

Patient's Date of Birth *

Month Day Year

Patient's Birth Sex *

- ○ Male
- ○ Female
- ○ Prefer Not to Say

Please provide your **preferred phone number** so we can contact you to schedule your appointment. Additionally, the **email address** you provide will be used to send your patient portal invitation, where you can create your account and complete all necessary new patient paperwork before your first visit.

Patient's Gender Identity

- ○ Male
- ○ Female
- ○ Transgender Male
- ○ Transgender Female
- ○ Nonbinary
- ○ Other/Prefer Not to Say

Parent's Contact Number *

Please enter a valid phone number.

Parent's Email Address *

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

How did you hear about us? *

- ○ Current Patient or Friend
- ○ Insurance
- ○ Therapist/Psychologist
- ○ Primary Care Provider
- ○ Online: Google or Social Media
- ○ Other Psychiatrist/Specialty Provider

Who can we specifically thank for referring you? (Ex: insurance name, doctor's name, friend's name, website, etc.) *

Name of parent filling out this form *

Who does the patient live with? *

Who has legal custody? Please describe the arrangement. *

If the patient's parents are separated or divorced and share custody, we require permission from both parents in order to schedule an appointment

If applicable, can we send a consent form to the other parent *

- ○ Yes
- ○ No
- ○ Not applicable

Name of Other Parent/Guardian

Phone Number of Other Parent/Guardian

Email Address of Other Parent/Guardian

What is your child looking to get treatment for? Check all that apply *

- ☐ Anxiety
- ☐ Depression
- ☐ Treatment Resistant Depression
- ☐ Bipolar Disorder
- ☐ ADHD/ADD
- ☐ Oppositional Defiant Disorder (ODD)
- ☐ Autism
- ☐ Personality Disorders
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Schizophrenia
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Complex Post Traumatic Stress Disorder
- ☐ Self-Esteem Issues
- ☐ Trauma
- ☐ Gender and Sexual Identity
- ☐ Substance Abuse
- ☐ Eating Disorder
- ☐ Life Transitions
- ☐ Other

Please provide any additional information if needed

What type of treatment would you like to receive? Check all that apply *

- ☐ Psychiatry- Medication
- ☐ Therapy- Talking and Problem-Solving Techniques
- ☐ Treatment Resistant Depression treatment- TMS, Spravato, Ketamine
- ☐ Psychoeducational Testing

Which are the best days for a first appointment? *

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday

Which are the best times for a first appointment? *

- ☐ Morning (9am-12pm)
- ☐ Early Afternoon (12pm-3pm)
- ☐ Late Afternoon (3pm-5pm)

Please provide a list of all current and previous medications taken for mental health. Include the medication name and dosage. *

Primary Insurance Company *

Member ID *

Secondary Insurance Company

Member ID

During the past two (2) weeks, how much or how often has your child been bothered by the following problems?

Has your child EVER...

If yes, please list the date and reason for the hospitalization.

COVID-19 & Infectious/Communicable Disease Liability Waiver

Please read and acknowledge the following:

COVID-19 Safety Measures
Our office is no longer implementing additional COVID-19-specific precautions (such as universal masking, enhanced distancing, or routine screening) beyond standard infection control protocols required by healthcare regulations.
Personal Responsibility
By entering our facility, you acknowledge that:
You are voluntarily seeking care and services at our office.
You understand that COVID-19 remains a communicable illness with potential health risks.
You are responsible for your own personal precautions (e.g., masking, distancing, sanitizing) if you so choose.

Health Disclosure
You agree to inform our staff prior to your visit if you:
Have tested positive for COVID-19 within the past 10 days.
Have been exposed to someone known or suspected to have COVID-19 within the past 10 days.
Are experiencing any symptoms consistent with COVID-19 (including but not limited to fever, cough, fatigue, or loss of taste or smell).

Assumption of Risk
Despite our efforts to maintain a clean and safe environment, you acknowledge that:
There is an inherent risk of exposure to COVID-19 in any public or healthcare setting.
By attending your appointment, you voluntarily assume all risks related to potential exposure.

HIPAA Policy

Our office is committed to maintaining compliance with HIPAA regulations to ensure the privacy and security of patient information. Once an appointment is scheduled, the patient will receive our full HIPAA policy to review, outlining our practices and procedures for safeguarding their confidential health information.

Establishing Care with Our Practice

A psychiatric evaluation by Dr. Robbins or one of our clinicians does not ensure you will become a patient of the practice. It may be his/her opinion that you need more intensive services from what can be provided in the office. At that time, Dr. Robbins will provide you with referrals of programs you can receive such services from. If after the completion of your evaluation with your clinician, he or she feels you can be treated in the office, certain recommendations will follow. You will be required to follow the recommendations provided by the clinician during the course of treatment. If for any reason, the clinician feels you are not complying with the recommendations, you may be discharged from the office for non compliance. Other reasons you may be discharged from the office include: reEpeatedly missing appointments, not being responsive to phone calls from office, failure to make payments in a timely manner or any misuse of medications being prescribed to you by your clinician. If you are discharged from the office and are being prescribed medications, your clinician will make sure to provide you with enough refills for up to 1-2 months to give you ample time to connect with a new provider.

Working with Our Clinicians

I understand that my initial appointment may be scheduled with either Dr. Robbins, a licensed psychiatrist, or with a qualified psychiatric nurse practitioner, depending on provider availability and scheduling needs. While you can request a first appointment with Dr. Robbins, earlier appointments may be available with one of our experienced psychiatric nurse practitioners. All psychiatric nurse practitioners in this practice are fully licensed, highly trained, and work in close collaboration with Dr. Robbins. If I begin care with Dr. Robbins, I understand that follow-up appointments may be scheduled with a psychiatric nurse practitioner if recommended as appropriate for my treatment plan. Regardless of which provider I see, my care will remain under the clinical oversight of Dr. Robbins to ensure quality, consistency, and continuity. By signing below, I consent to receive care from the qualified providers within this practice as determined by clinical judgment and availability.

I affirm that all information provided above is accurate and complete to the best of my knowledge. I understand that submission of this information does not guarantee an appointment with this practice. I acknowledge that the New Patient Coordinator may review my information and, based on clinical and logistical considerations, may recommend an alternative provider or practice better suited to my needs.

Patient Name *

Parent/Guardian's Name *

Date *

if printed, sign here