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Referral Information Form

Date: _____

Name: _____ Date of Birth: _____

Social Security Number: _____ Age: _____ Gender: M or F (circle)

Address: _____

Phone: _____ Best Time to Call: _____

Email: _____ Can I Leave Message? Y or N (circle)

Referral Source:

Name: _____ Phone Number _____

Concerns:

Appointment Availability: (Circle all that apply)

Days: Monday Tuesday Wednesday Thursday Friday Saturday

Times: Morning Afternoon Evening

Payment Information:

Insurance Name: _____

Customer Service Number: _____

Claims Address: _____

Client ID Number: _____

Group ID Number: _____

Pre-authorization Required: Y or N (circle) Authorization Number: _____

Deductible Amount: _____ Deductible Met? Y or No (circle)

Co-pay or Co-insurance Amount: _____