

Sonya Vieira, M.D.

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New York, NY 10001

(646) 265-9484

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Cell Home Work

Secondary Phone: _____ Cell Home Work

Email (only used with your permission): _____

Date of Birth: _____ Age: _____ Gender: _____

Marital Status: _____ Occupation: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Authorization: I hereby authorize Dr. Sonya Vieira to provide psychiatric and psychotherapeutic care, administer tests, medications, and treatments. I understand that I am financially responsible for all charges whether or not covered by insurance.

Patient Signature Date

Consent to Communication via Email: I hereby consent to have Dr. Sonya Vieira communicate with me via email. I understand that email is not a confidential method of communication. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on email.

Patient Signature Date