

Contact Information Form

(for medically-related screenings)

**Carol Pierce-Davis,
Ph.D.
Psychologist**

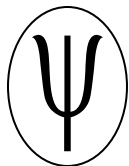
**National Register of
Health Service Providers**

**Texas Health Service
Provider**

**Board Certified
Diplomate Fellow
Psychopharmacology**

**Board Certified
Diplomate Fellow
Serious Mental Illness**

**Board Certified
Medical Psychologist**



4131 Spicewood Springs Road
Suite K6
Austin, TX 78759

Phone: 512-413-3025
Fax: 800-420-4784

drpiercedavis@gmail.com
www.carolpiercedavisphd.com

Date _____

Referred by _____

Anticipated Procedure _____

Name _____ DOB _____

Age _____ Telephone (mob) _____

Email _____

Employer _____

Name _____ DOB _____

Age _____ Telephone (mob) _____

Email _____

Employer _____

Home Address _____

City, State, Zip _____

Dr. Pierce-Davis has informed me that Screenings for medical procedures are not reimbursable through insurance companies.

Signature _____

Signature _____