# Judy Schrader, LMHC

**Licensed Mental Health Counselor**

***Beachside Counseling & Wellness, LLC*** **122 4th Ave, Suite 200, Indialantic, FL 32903**

**Ph: 321-327-3793**


**Client Information** **Date: _____**

Last Name:_____First Name:_____MI:_____

Address: _____

City:_____State:_____Zip: _____

Birthplace: City/ State/ Country_____

Home Phone:_____Work Phone:_____Cell Phone:_____

(Please check best number to leave message)

Email: _____ Would you like reminder messages via email? Y N

Would you like to be added to our email list to receive updates about our services and therapy groups? Y N

Gender: (M/F) _____Date of Birth: _____ Social Security No: _____

**Referred by:** _____ Phone: _____

May I thank this individual for the referral? (Please Initial) Yes: _____ No: _____

**Responsible Party Information (IF OTHER THAN CLIENT)** **Relationship**: _____

Last Name:_____First Name:_____MI:_____

Address:_____

City:_____State:_____Zip:_____

**Employer Information**

Employer: _____ Phone: _____

Address: _____

City:_____State:_____Zip:_____

**Emergency Contact Information**

Name:_____ Relationship: _____ Phone:_____

**Please complete the other side of this form**

**The self-pay fee for psychotherapy, initial consultation is $175.00. All following visits are $160.00.**

**The self-pay fee for couple's therapy visits is $200.00.**

**The self-pay fee for medical psychological evaluation is $250.00.**

**All visits covered by insurance are subject to your policy's copay and/or deductible.**

**I have reviewed the Introduction to Psychotherapy and Financial Agreement information, and I voluntarily agree to participate in psychotherapy services.**

_____ _____ _____

Print name Signature of client or responsible party Date

## Insurance Information Judy Schrader, LMHC

Please fill out the following information only if you wish to use your insurance to pay for your therapy, and have verified with my office that I am a participating provider.

**Name of Primary Insurance: _____ Phone: _____**

**Group Name or #: _____ Member ID #: _____**

**Policy Holder's Name (If Different from Client): _____**

**Address: _____**

**Insured Party ID #: _____ Birth Date: _____**

**Relation to Client: _____ Authorization #: _____**

**Do you have an EAP? No Yes**

**Do you have any other insurance? No Yes If yes, please notify the office manager.**

**Please read and sign the following.**

**I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Judy Schrader, LMHC. I also request payment of government benefits either to myself or to the party who accepts assignment as indicated on the insurance claim form.**

**Signature: _____ Date: _____**