Patrick Aragon, Psy.D.

Licensed Psychologist

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:_____

The self-pay fee for initial consultation is $200.00. The fee for all following visits will be determined during the initial assessment appointment.

I have reviewed the Consent for Participation and Financial Agreement information, and I voluntarily agree to participate in neuropsychological testing and/ or psychotherapy services.

_____ _____ _____

Print name Signature of client or responsible party Date

Insurance Information **Patrick Aragon, Psy.D.**

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 Patrick Aragon, Psy.D. 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: _____