Jennifer Scott, M.D.

Psychiatrist

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

Ph: 321-327-3793

Client Information **Date of Birth_____** **Today's 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

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: _____

Emergency Contact Information

Name:_____ Relationship: _____ Phone:_____

Please complete the other side of this form

The self-pay fee for initial consultation is $300.00. All following visits are $150.00. If more than a year has passed since your last visit with me, we will need to schedule more time than a regular follow up and the fee will be $300.00

I have reviewed Financial Agreement information, and I voluntarily agree to participate in mental health treatment.

_____ _____ _____

Print name Signature of client or responsible party Date

Insurance Information **Jennifer Scott, MD**

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 #: _____

Please read and sign the following.

I authorize the release of any medical or other information necessary for medication management to my insurance company.

Signature: _____ Date: _____