PATIENT INFORMATION
ANDREW LAGOMASINO, PSYD, ABPP
CORAL GABLES THERAPY
250 CATALONIA AVENUE SUITE 607
CORAL GABLES, FL 33134 (305) 441-6655

Patient's Name_______________________________________ Date of Birth:___________ Gender: F____ M_____

Residence Address_____________________________________ Marital Status: Single _______ Married_________ Widowed_____ Divorced_________

City and Zip Code______________________________________

Phone (Home):_______________________________ Cell: ______________________________________

Occupation:_________________________________ Phone (Business):_____________________________

Employer:__________________________________ Address:______________________________________

If Patient Is a Minor:

	Father	Mother
Name:	______________________	______________________
Address:	______________________	______________________
City / State / Zip:	______________________	______________________
Telephone:	______________________	______________________
Name of Employer:	______________________	______________________
Business Phone:	______________________	______________________
Occupation:	______________________	______________________

Whom May We Thank For Referring You? ____

I authorize this office to release the limited information about my sessions to my insurance company that they require to process claims. I understand that Coral Gables Therapy may be able to assist me in obtaining accurate insurance benefit information, but the responsibility for knowing and understanding my benefits is ultimately mine. I authorize payment of all charges to Andrew Lagomasino PsyD, ABPP/Coral Gables Therapy. I agree to be financially responsible for all charges not paid by my insurance company.

A missed session is a session for which I no show, cancel, or reschedule with less than 24 hours' notice. I agree to pay the full cost of missed sessions, not just my copay, which insurance companies never reimburse. I have the option of calling to do a phone session if I cannot attend my session in person, to avoid being charged for a missed a session. My signature below indicates that I understand and accept these conditions.

Patient or Parent Signature:_____________________________________ Date:____________________