Gustavo J. Cuadra, M.D.

Board-Certified Psychiatric Care

3023 Eastland Blvd. Suite 106
Clearwater, FL 33761

Phone: 727-265-1781
Fax: 727-330-7578

PATIENT INFORMATION

Last Name_____ **First Name**_____ **MI**____

Address_____ **City**_____ **State**____ **Zip**_____

Home Phone_____ **Social Security No.**_____ **DOB**_____

Work Phone_____ **Age**_____ **Sex**_____ **Marital Status**_____

Cell Phone _____ **Prefered Confirmation Phone**_____

RESPONSIBLE PARTY NAME

Insured's Employment Information
Employer_____
Address_____
Business Phone_____ **May we contact you at work?Yes**_____ **No**____

INSURANCE INFORMATION

Company_____ **Policy No.**_____
Address_____
Phone Number_____ **Social Security Number of Policy Holder**_____
Policy Holder's Name_____ **DOB**_____

EMERGENCY INFORMATION

Person to contact in case of emergency_____
Address_____ **Phone No.**_____
Relationship _____ **Who referred you to this practice?**_____

AGREEMENT FOR SERVICES

1. Consent is hereby given to Dr. Gustavo J. Cuadra to render mental health services/treatment to my child or myself.
2. Confidentiality is assumed unless client expresses harm to self and/or others or in case of judicial mandates (i.e. court subpoenas/orders).
3. I authorize the release of any medical information necessary to process this or a related claim to my insurance company or the billing service.
4. I authorize payment of insurance benefits to Gustavo J. Cuadra or other treating professionals.
5. I, the Undersigned, understand that I am responsible for payment of services and understand that any co-payment or deductible is due when services are rendered..
6. I understand that I am responsible for any charges not covered by my insurance or if payment has not been received from my insurance company within 60 days from the date of service.
7. I agree to pay all incurred costs and authorize release of all personal demographics should bill be forwarded to collections.
8. If you are unable to keep an appointment, please call the office at least 24 hours before the appointment. I understand that a charge will apply if I fail to provide the 24-hour notice of cancellation.
9. I understand that there will be a charge for completion of forms for medical records, disability, employment, prescription pre-authorization, etc., and also for any requested typewritten letters and/or reports.

Please sign this document in the presence of a member of Dr. Cuadra's staff

Signature _____ **Date:**_____

Print Name _____

ParentGuardian _____ **Date:** _____

Witness _____ **Date:** _____

EMAIL ADDRESS_____

CURRENT PHARMACY_____ PHONE_____