I-BOS Counseling Center, LLC
Fax: (239) 242-6389

2503 Del Prado Blvd. S. Ste. 410
Cape Coral, Florida 33904

Client Demographic Form

Name(s):_____

Address: _____
(Street) (Apt.) (County)

_____
(City) (State) (Zip)

DL Number: _____

Date of Birth: _____/_____/_____ Age: _____

Social Security Number: _____-_____-_____

Please put a check in the box next to the number where you may be best reached:

☐ Home Phone: (____) _____-_____ ☐ Work Phone: (____) _____-_____

☐ Cell Phone : (____) _____-_____ ☐ Other: (____) _____-_____

Email:_____

Responsible Party (Parent if Applicable):_____
Name Relationship
DOB:_____ DL#:_____ Phone:_____
Home Mobile
Address (if different from above):_____
Employer_____Y_____N___
Business Work Phone May I call there?
PERSON TO CONTACT IN EMERGENCIES: _____
Name/Relationship Phone Number

Office Policy

All Payments are due at the time of service. If, **for any reason,** payment is not received at time of service, client will be allowed five (5) business days to make payment in full unless other arrangements are made.
I understand that payment due is based on I-BOS Counseling Center's best estimate. I understand I am responsible for any fees not covered by the insurance plan. If the debt is not paid, it will be sent to collections.

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_____
INITIAL

Returned checks require a $25.00 per check charge in addition to payment of Fees accrued.

_____
INITIAL

THIS OFFICE MUST BE CONTACTED AT LEAST **24 HOURS** PRIOR TO APPOIMTMENTS TO AVOID MISSED APPOINTMENT CHARGE.

_____
INITIAL

FEE SCHEDULE

Individual Psychotherapy, Parent/Family Conference Therapy
20 Minutes..... $70.00

1 Hour (50 Min.) if payment not received at time of service $150.00
1 Hour (50 Min.) if payment received at time of service……$150.00
Missed Appointments……$150.00
Brief Phone Calls…… No Charge
Phone Consult (over 15 Minutes)…… Based on Hourly Rate
Outgoing Correspondence re: evaluation or treatment of a client
½ page or less…… No Charge
Comprehensive summaries, evaluations, letters or reports……$150.00 per Hour
On site observations, staffing, follow up conferences, court
(includes travel time)……$150.00 per Hour

_____
INITIAL

Occupation/School_____ Number of Years:_____
Education: Highest Level Completed _____ Any Degrees _____ Majors _____
Marital Status (circle): SINGLE MARRIED PARTNERED SEPARATED DIVORCED
WIDOWED COHABITATING OTHER
If ever married, how many times? _____ If ever divorced, how many times? _____
Place you live in (circle): HOME APARTMENT CONDO ROOM HOTEL OTHER

Family Physician: _____
Name Phone Number
Medications Currently Taking: _____
Any Medical Conditions: _____

Chief Complaint/Reason for Referral:
_____

_____

_____

****CONSENT FOR TREATMENT****

I hereby authorize this therapist to evaluate and render appropriate counseling service to myself/my child. This consent is knowingly and freely given. I further understand that ALL INFORMATION given by myself/my child or any member of my family to the therapist is CONFIDENTIAL and WILL NOT be released except by WRITTEN client permission or as provided by law.

I understand the Office Policies as stated above and accept full responsibility for payment of services rendered.

_____ _____
Therapist Client (or Parent, if Child is a Minor)

_____
Date

CLIENT REFERRED BY: _____
For Office Use Only:
☐ Benefits have been run
☐ Form copied for IBOS
☐ Client number received