

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:

n Home Phone: (____)____-____ n Work Phone: (____)____-____

n Cell Phone : (____)____-____ n Other: (____)____-____

Email: _____

Responsible Party (Parent if Applicable): _____

DOB: _____ DL#: _____ Name _____ Relationship _____
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.

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 APPOINTMENTS TO AVOID MISSED APPOINTMENT CHARGE.

INITIAL

FEE SCHEDULE

Individual Psychotherapy, Parent/Family Conference Therapy

1 Hour (50 Min.) if payment not received at time of service \$200.00

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1 Hour (50 Min.) if payment received at time of service.....\$200.00
 Missed Appointments\$100.00
 Brief Phone CallsBased on Hourly Rate
 Phone Consult (over 15 Minutes)Based on Hourly Rate
 Outgoing Correspondence re: evaluation or treatment of a client
 ½ page or less Based on Hourly Rate
 Comprehensive summaries, evaluations, letters or reportsBased on Hourly Rate
 On site observations, staffing, follow up conferences, court
 (includes travel time)..... Based on Hourly Rate

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): HOUSE 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: _____

