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

2503 Del Prado Blvd. S. #410
Cape Coral, FL 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.

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INITIAL

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

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INITIAL

FEE SCHEDULE

Individual Psychotherapy, Parent/Family Conference Therapy

20 Minutes……………………………………………………………….$40.00

1 Hour (50 Min.) if payment not received at time of service $90.00
1 Hour (50 Min.) if payment received at time of service……$90.00
Missed Appointments ……………………………………………$90.00
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… …………$90.00 per Hour
On site observations, staffing, follow up conferences, court
(includes travel time)………………………………… $90.00 per Hour

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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 <u>any member of my family</u> 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.

__________________________ __________________________
Registered Intern 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