

### 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): \_\_\_\_\_

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 Calls..... Based 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 reports..... Based 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): 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

