

Client Demographic Form

Name(s): _____

Address: _____

(Street) (Apt.) (County)

(City) (State) (Zip)

Driver's License 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.

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
20 Minutes.....\$65.00

1 Hour (50 Min.) if payment not received at time of service \$135.00

1 Hour (50 Min.) if payment received at time of service.....\$135.00

MISSED APPOINTMENTS... \$135.00

Brief Phone CallsNo 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... \$135.00 per Hour

On site observations, staffing, follow up conferences, court

(includes travel time)..... \$135.00 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: _____

Medical Conditions: _____

How can we help you?

Do you have Medicare? _____ Yes _____ No

****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

