

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	
20 Minutes.....	\$50.00



1 Hour (50 Min.) if payment not received at time of service \$120.00
 1 Hour (50 Min.) if payment received at time of service.....\$120.00
 Missed Appointments.....\$120.00
 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.....\$120.00 per Hour
 On site observations, staffing, follow up conferences, court
 (includes travel time).....\$120.00 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

