I-BOS Counseling Center, LLC
Fax: (239) 242-6389
2503 Del Prado Blvd. S. Ste. 410
Cape Coral, Florida 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:

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

n Cell Phone : (____)_______-______ n 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

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

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:
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____

____

****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:
n Benefits have been run
n Form copied for IBOS
n Client number received