I-BOS Counseling Center, LLC 2503 Del Prado Blvd. S. Ste. 410

Fax: (239) 242-6389 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.

. \_\_\_\_\_\_\_\_\_

# 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 APPOIMTMENTS 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

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