IBOS Counseling Center, LLC
Fax: (239) 242-6389

2503 Del Prado Blvd. S. #410
Cape Coral, FL 33904

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 <u>not</u> covered by the insurance plan. If the debt is not paid, it will be <u>sent to collections</u>.

. _____
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
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 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… ……$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): HOUSE 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: _____