

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): _____
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
1 Hour (50 Min.) if payment not received at time of service \$250.00

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Missed Appointments.....	\$250.00
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:

****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
