

**Client Information Form**

**Integrative Therapeutic Solutions**

Uptown Denver: 1756 High St. ♦ Denver, CO ♦ 80218  
(P) 303-388-8144 ♦ (F) 303-756-3628 ♦ ITSTherapyDenver.com

**Client Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Previous Counseling and/or Psychiatric Treatment:**

Name of Provider/s: \_\_\_\_\_

Length of Treatment: \_\_\_\_\_

Medications (please include dosages if known):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**Who were you referred by?**

Name: \_\_\_\_\_

May I contact this person to thank them? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Responsible Party:**

*If you are the parent or legal guardian of a client under the age of 18, please complete the following with your information. If you are over the age of 18, please proceed to the next section of this form.*

Name of Parent or Legal Guardian: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Responsible Party #2:**

*For clients with separated parents/guardians, please list additional information below.*

Name of Parent or Legal Guardian: \_\_\_\_\_ \

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## ELECTRONIC PAYMENT AUTHORIZATION

### Form of Payment

Please indicate the information associated with debit or credit card you wish to use for all services rendered through this practice. Charges will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Monthly Statements are provided via email. You will receive an initial email with instructions to create an account that allows you to access your secure and confidential statements. Please indicate the email address you prefer your statements to be sent to. Statements may be sent to multiple emails if requested:

Email: \_\_\_\_\_

I authorize all service fees to be deducted from the card ending in \_\_\_\_\_ (last four digits of the card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s)

\_\_\_\_\_

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. \*By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_

Payments are processed by Therapy Partner.

Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY

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### **Debit or Credit Card Information:**

Please provide your payment information below. The debit or credit card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card Type (circle one):    Visa    MasterCard    Discover

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

CVV code \_\_\_\_\_ (last three digits on back of card)

## APPOINTMENT REMINDERS

If you would like to receive appointment reminders, please check which of the following formats you prefer and enter the corresponding contact information:

\_\_\_\_\_ Text Message to: \_\_\_\_\_

\_\_\_\_\_ Phone Call to: \_\_\_\_\_

\_\_\_\_\_ Email to: \_\_\_\_\_

\_\_\_\_\_ I agree to receive communications from ITS as selected above

**Initial**