Client Information Form

Integrative **T**herapeutic **S**olutions
Uptown Denver: 1756 High St. ◆ Denver, CO ◆ 80218
(P) 303-388-8144 ◆ (F) 303-322-3525 ◆ 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 <u>your</u> 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

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:

_____ Phone Call to: _____

_____ Email to: _____

_____ I agree to receive communications from ITS as selected above
Initial