



**FINANCIAL SCHEDULE**

NAME: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

GROSS INCOME \_\_\_\_\_ (Please fill in amount and circle applicable pay period)

Family Member(s) Amount \_\_\_\_\_ per year/ month/ week

Amount \_\_\_\_\_ per year/ month/ week

Amount \_\_\_\_\_ Per year/month/week

INSURANCE  Yes  No

Deductible \$ \_\_\_\_\_ Has deductible been met  Yes  No

NAME OF INSURANCE COMPANY: \_\_\_\_\_

NAME OF SECONDARY INSURANCE: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Intake Worker

\_\_\_\_\_  
Date

**SECTION II ONLY APPLIES IF YOU ARE PRIVATE PAY.**

SECTION II (To be completed by The Counseling Connection Intake Worker)

Actual Cost for Evaluation Interview Individual Session \$ 205.00

Actual Cost per hour for Following Individual Session \$ 180.00

Your Adjusted Fee for Today's Evaluation \$ \_\_\_\_\_

Your Adjusted Fee for Individual Sessions  
Based on sliding fee Scale \$ \_\_\_\_\_

*As a patient/parent I agree to pay my assessed fee as stated above per hour at the time services are rendered.*

**INTAKE WORKER:** \_\_\_\_\_ **DATE** \_\_\_\_\_

**YOUR SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_