

FAMILY CONCERN COUNSELING

FEE ASSISTANCE APPLICATION

Name: _____ Spouse: _____

Address: _____ Home Ph #: _____

City/St/Zip: _____ Work Ph #: _____

Place of Employment: _____

Spouse's Place of Employment: _____

Are you or anyone in your immediate household a missionary or employed by a church? ____ Yes ____ No

Does your household have a trust, inheritance, stock, savings that is accessible:

In excess of \$5,000 (excluding IRA)? ____ Yes ____ No

Do you have primary or secondary insurance available to your family that covers counseling/psychological services at Family Concern from which you will be requesting reimbursement? ____ Yes ____ No

If "Yes," you must pay at the full rate.

Note: It is considered fraud to use the adjusted fee scale when insurance/mental health benefits are available.

Are there additional reasons/circumstances due to which you should be considered for a reduced fee?

Proof of Payment: Yes _____ No _____ Verified by: _____ Date: _____

TOTAL NUMBER OF PERSONS IN HOUSEHOLD: _____

TOTAL ANNUAL HOUSEHOLD INCOME AFTER TAXES: \$ _____

MINISTERIAL HOUSING/PARSONAGE ALLOWANCE: \$ _____

If applicable: Child Support: **paid out / received** yearly (please circle which) \$ _____

PLEASE ATTACH COPIES OF TWO OF YOUR MOST RECENT PAY STUBS FOR EACH HOUSEHOLD WAGE EARNER FOR VERIFICATION. IF YOU ARE SELF-EMPLOYED ATTACH A COPY OF THE LAST YEAR'S INCOME TAX RETURN.

In most cases, reduced fees will be limited to twelve (12) sessions.

I UNDERSTAND THAT ALL REDUCED FEES MUST BE PAID AT THE TIME OF SERVICE. (Please Initial Box)

We (I) declare that we (I) have reviewed the information above; and to the best of our (my) knowledge and belief, is true, correct and complete. Furthermore, I understand this agreement is based on not having insurance benefits available for reimbursement for these mental health services.

Signed: _____

Date: _____

TO BE COMPLETED IN OFFICE:

Approval Date: _____

Fee: _____

Effective Date: _____

Grant or Other Subsidy: _____

Approved By: _____

Client #: _____

Sliding Scale - Annual Household Income & Fee

Please check one

14,999 and under	\$30	<input type="checkbox"/>	30,000 to 34,999	\$70	<input type="checkbox"/>
15,000 to 19,999	\$40	<input type="checkbox"/>	35,000 to 39,999	\$80	<input type="checkbox"/>
20,000 to 24,999	\$50	<input type="checkbox"/>	40,000 to 44,999	\$90	<input type="checkbox"/>
25,000 to 29,999	\$60	<input type="checkbox"/>	45,000 to 50,000	\$100	<input type="checkbox"/>

Clients should understand that all professional services furnished are charged directly to the patient. Payments are to be made at each visit unless prior arrangement has been made with the therapist. We regret that at this time YFC Family Concern cannot bill your insurance company, however we are willing to provide whatever documentation possible that you may need to obtain a reimbursement from your insurance company.

Cancellation Policy: If an appointment is missed or if you cancel less than 24 hours in advance a full fee will be billed. This is necessary because we have other clients that we may need to schedule at the time we are holding for you. If a third party provider normally pays your fee you are still required to pay the cancellation fee.

Authorization for Treatment and Financial Agreement:

I have read the above information, and I understand my rights and limitations as a client receiving counseling from a trainee, intern or licensed therapist at Family Concern Counseling. I agree to abide by the terms and conditions set out in this Informed Consent document. A signed copy of this Informed Consent has been given to me for my records. I consent to therapy, including evaluation, treatment, and/or referral.

I authorize treatment of the person named below and I agree to pay all charges incurred for me and for members of my family for which I am responsible promptly upon presentment thereof, unless protested in writing within thirty days of date of services. In the event legal action should become necessary to collect an unpaid balance due for services rendered to my family, or me I agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

In consultation with the Therapist I agree to the following fee: \$ _____

From above sliding scale

I also agree to pay the full fee, as contracted of \$ _____ if I do not show for an appointment or if I cancel less than twenty-four hours in advance. _____ (Initial here)

Signature: _____ Date: _____
Person(s) Responsible (Parent or Legal Guardian)

Client Signature: _____ Date: _____
If different from person responsible

Therapist's Signature: _____ Date: _____

Beginning Date of Therapy: _____ Termination Date: _____