

# Family Counseling Connection

1021 Quarrier Street \* Suite 414 \* Charleston, WV 25301 (304) 340-3676

## FINANCIAL SCHEDULE

### SECTION I

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

MEDICAL INSURANCE YES NO Deductible \$ \_\_\_\_\_ (has  
Circle one been met for this year)  
YES NO

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

NAME OF SECONDAYR INSURANCE: \_\_\_\_\_

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

Actual Cost for Evaluation Interview Individual Session \$ 145.00

Actual Cost per hour for Following Individual Session \$ 115.00

Actual Cost per hour for Following group Session \$ 90.00

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

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

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

*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** \_\_\_\_\_

PLEASE READ "AGENCY FEE POLICY" ATTACHED