

**Carroll Counseling Center, LLC  
Financial Assessment**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Responsible Party(ies): \_\_\_\_\_ Number of Dependents: \_\_\_\_\_

Portion covered by insurance: \_\_\_\_\_

Phone: \_\_\_\_\_ (day) \_\_\_\_\_ (evening) \_\_\_\_\_ (cell)

The following information is requested so that our staff can give you the best advice concerning planning for care needs not covered by insurance. This information will be used only by Carroll Counseling Center, LLC personnel and will be kept strictly confidential.

<u>Monthly Income</u>		<u>Monthly Expenses</u>	
<u>Source</u>	<u>Amount</u>	<u>Source</u>	<u>Amount</u>
Salary:	_____	Mortgage/Rent:	_____
Retirement:	_____	Car Note:	_____
Dividends/Interest:	_____	Child Support:	_____
Child Support:	_____	Alimony:	_____
Alimony:	_____	Insurance:	_____
Spouse's Salary:	_____	Utilities:	_____
Rental Income:	_____	Other: (give details)	_____
Disability:	_____		_____
Other:	_____		_____
<b>TOTAL:</b>	<b>\$ _____</b>	<b>TOTAL:</b>	<b>\$ _____</b>

<u>Assets</u>	
<u>Source</u>	<u>Amount/Value</u>
Savings Accounts:	_____
Checking Accounts:	_____
Stocks/Bonds:	_____
Real Estate:	_____
Motor Vehicles:	_____
Retirement Accounts:	_____
Insurance:	_____
Other: (give details)	_____
_____	_____
_____	_____
<b>TOTAL:</b>	<b>\$ _____</b>

I certify that the above information is true to the best of my knowledge. I understand that if I have misrepresented any of the above information, that any sliding fee plan approved for payment of services provided myself or my family may immediately and retroactively become invalid.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

<b>For Office Use Only:</b>			
Total Monthly Income	\$ _____	Adjusted Net Income	\$ _____
Total Monthly Expenses	\$ _____	Session Charge	\$ _____
<b>Total Net Income</b>	<b>\$ _____</b>		