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.

Monthly Income		**Monthly Expenses**	
Source	**Amount**	**Source**	**Amount**
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:			
TOTAL:	**$**_____	**TOTAL:**	**$**_____

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

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: _____

For Office Use Only:			
Total Monthly Income	**$**_____	**Adjusted Net Income**	**$**_____
Total Monthly Expenses	**$**_____	**Session Charge**	**$**_____
Total Net Income	**$**_____		

D:Joan/financial assessment
Revised 2/7/2000