ADULT, CHILD & FAMILY COUNSELING

Sliding Scale Fee Schedule

(circle the appropriate fee for you)

Combined Gross Family Income	**Therapy Fee Per Session***
$10,000 & Below	$30
10,001 – 15,000	$35
15,001 – 20,000	$40
20,001 – 30,000	$45
30,001 – 40,000	$50
40,001 – 50,000	$55
50,001 – 60,000	$60
60,001 – 70,000	$65
70,001 – 80,000	$70
80,001 & Up	$75

*** Payment is by check or cash**

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Statement of Understanding and Consent for Treatment

BENEFITS AND RISKS OF THERAPY:

Research has shown that therapy can help a wide variety of problems for children, adolescents, and adults. However, because therapy is a cooperative effort between client and therapist, participation in therapy does not guarantee problem resolution or that the client necessarily will feel better. As with any treatment, whether psychological or medical, therapy should be entered into with appropriate consideration of the potential benefits and risks. If you have any questions about what to expect from therapy, please ask your therapist.

CONFIDENTIALITY:

Records and information collected about clients will be held and released in accordance with state and federal laws governing confidentiality of client records and information. Disclosure of information regarding services provided to the client is generally released to another party only with the client's written permission. Exceptions to this rule include the following cases: 1) when there is imminent danger to the client or another person, 2) when child abuse or neglect is suspected, 3) when disclosure must be made to medical personal in a medical emergency, and 4) when the therapist is compelled by law to disclose client records or information.

CLIENTS WITH DISABILITIES:

It is the policy of **AC&F Counseling** to accommodate clients with disabilities, pursuant to federal and state law. Any client with a disability who needs accommodations should inform the therapist prior to receiving services.

NONDISCRIMINATION POLICY:

In accordance with Title VI of the Civil Rights Act of 1964 **AC&F Counseling** does not discriminate against participants or clients on the basis of race, color, or national origin. Services are offered to all eligible persons.

CONSENT FOR TREATMENT/RESPONSIBILIES OF CLIENTS:

I do hereby authorize and give my consent to **AC&F Counseling** to provide treatment in accordance with the customary standards of practice specified by the state and federal laws, regulatory agencies, and professional discipline governing **AC&F Counseling**. **AC&F Counseling** does not overbook appointments. Each appointment is a reservation of resources specifically for you. Applicable charges are made for appointments not canceled within 24 hours prior to the appointment.

I have read, understand and agree to the conditions of treatment described in this document.

____________________________________ _________________

Client Signature / Parent or Guardian **Date**

Adult Child
Family
Counseling

Adult, Child & Family Counseling

Client Information

Date:__________

Name: ___________________________Parent/Guardian ________________________

Address: ____________________________ City: _____________ St: ___ Zip:_______

Home Phone: ________________ Okay to call: Yes __ No __

Cell Phone: _________________ Okay to call: Yes __ No __

Work Phone: ________________ Okay to call: Yes __ No __

Date of Birth: ____________ Age: ______ Highest Grade Level: __________________

Marital Status: Single __ Married __ (years married ___)Widowed __ Separated __
Cohabitating __ Divorced ___ (number of years divorced ___)

Spouses' Name: _____________________ DOB: __________ Age: ______

Cell Phone: ______________ Okay to call Yes __ No __

Work Phone: ______________ Okay to call Yes __ No__

Other Household Members: Relationship Age

______________________ _____________________ _____

______________________ _____________________ _____

______________________ _____________________ _____

How did you hear about this counseling service? ___________________________

Emergency Contact: Name ______________________ Relationship ______________

Phone number: Daytime ______________ Evening ______________

ADULT, CHILD & FAMILY COUNSELING

Client Information

Name: _______________________

PROBLEM INFORMATION:

For whom are you requesting counseling? _____________ If other than you what is your relationship to them? ______________________

Briefly describe the nature of the problem: ___________________________________

____

____

Have you (or the person who will be receiving counseling) ever received outpatient counseling? Yes __ No __

If yes, from whom? ________________________________ When? _______________

Have you (or the person who will be receiving counseling) ever received inpatient treatment? If yes from whom? _______________________ When? _______________

Are you currently being treated by a mental health professional? Yes __ No __ If yes from whom? ____________________When __________________

Medication prescribed for mental health issues:

____

____

____

ADULT, CHILD & FAMILY COUNSELING

Medical Information

Name: ______________________________ Date: ______________

MEDICAL INFORMATION:

Which of the following illnesses or complaints have you (the client) experienced?

___ Diabetes	___ Head Injury	___ Ulcer	___ Irregular menses
___ High Blood Pressure	___ Thyroid problems	___ Glaucoma	___ Difficulty Sleeping
___ Epilepsy	___ Seizures	___ Dizzy Spells	___ Loss of Appetite
___ Liver problems	___ Hepatitis	___ PMS	___ Herpes
___ Kidney problems	___ Asthma	___ Back Pain	___ Sexually Transmitted disease(s)
___ Headaches/Migraines	___ Respiratory problems	___ Frequent constipation	
___ Heart attack	___ Stroke	___ Loss of consciousness	___ Other ____________

What prescription medications are you currently taking and why?

Medication	Reason for taking it
1. __________________________	____
2. __________________________	____
3. __________________________	____
4. __________________________	____

Please identify any allergies that you have:

1. _________________________ 2. __________________________3. _________________________

What over the counter medications do you regularly take? ___________________________
____

Name and Phone number of your **Primary care Physician**: __________________________
____

When was the last time you saw your doctor? __________________ Why? ______________
____

The last time you had a physical? __________________

Adult Child Family Counseling