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

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