# Carroll Counseling Center, LLC
## Financial Assessment

Patient: _____ DOB: _____

Responsible Party(ies): _____ Number of Dependents: _____

Portion covered by insurance: _____

Phone: _____ (day) _____ (evening) _____

**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** |
| Savings Accounts: | _____ |
| Checking Accounts: | _____ |
| Stocks/Bonds: | _____ |
| Real Estate: | _____ |
| 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

carroll COUNSELING center

South Carroll Medical Center
1380 Progress Way, Suite 101
Eldersburg, MD 21784
Phone: 410-549-5181
Fax: 410-549-5182

**FINANCIAL AGREEMENT**

**Based on the attached financial assessment the following payment arrangements are made according to Carroll Counseling Center's Sliding Fee Schedule.**

**Type of Service(s)**

**Patient(s):**

**Provider(s):**

**Financial Term:**

**Effective Date:**

_____
**Date**
**Carroll Counseling Center**_____ _____
**Date**

**The above agreement is contingent upon the approval of Carroll Counseling Center, LLC (CCC), and will remain in effect until, and unless, Provider and/or CCC provides written cancellation notice to all concerned parties.**

**Should party obtain private insurance coverage acceptable by CCC, party will notify CCC prior to effective date of insurance or first date of coverage.**
**The above rates do not apply to any testing or other services not specified in the agreement. Patient is responsible for any missed appointment according to the terms agreed to at time of admission**

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evised 10/05/05