FOUNDATIONS BEHAVIORAL HEALTH SERVICES, INC.
FEE ASSESSMENT AND FINANCIAL REVIEW

Client Name: _____ **Date of Birth:** _____

INCOME SOURCE:

Please check the following sources of ***all household income***:

☐	Full-time employment	☐	Part-time employment	☐	Social Security (SSI)	☐	Social Security Disability (SSDI)
☐	Other Disability Pay	☐	Unemployment	☐	Worker's Compensation	☐	Alimony / Spousal Support
☐	Aid to Dependent Children (ADC)	☐	Child Support	☐	Savings	☐	General Relief / Welfare
☐	Pension/IRA/401K, etc.	☐	Family or Relatives	☐	Other: _____		

PRIMARY INSURANCE:

Client (or parent) occupation: _____ Employer: _____ Hire Date: _____

Employer Phone: _____ Employer City, State: _____

Monthly Gross Wages: _____ Medical Insurance Carrier: _____

Cardholder Name: _____ Cardholder Social Security Number: _____

Cardholder Date of Birth: _____ Relationship to Cardholder: _____

SECONDARY INSURANCE:

Spouse's occupation: _____ Spouse's Employer: _____ Hire Date: _____

Employer Phone: _____ Employer City, State: _____

Monthly Gross Wages: _____ Medical Insurance Carrier: _____

Cardholder Name: _____ Cardholder Social Security Number: _____

Cardholder Date of Birth: _____ Relationship to Cardholder: _____

FEE SCHEDULE FOR SERVICES

Psychiatric Assessment (1st Doctor Visit)	$325.00 per hour	Psychiatrist Appointment	$285.00 per hour
Diagnostic Assessment	$134.00 per hour	Individual Counseling	$123.00 per hour
Group Therapy	$34.00 per hour	Rapid Drug Testing	$25.00 per test**
		IOP	$180.00/session

*****No Discount on Drug Testing / Payment Due At Time Of Service on All Services*****

Signature of client/patient or legal representative or agent _____ Date _____

Signature of Staff Member Completing Fee Assessment _____ Date _____

FOR STAFF USE ONLY

GROSS HOUSEHOLD MONTHLY INCOME: $_____ **ANNUAL HOUSEHOLD INCOME: $_____**

NUMBER OF HOUSEHOLD MEMBERS: _____
(should match Client Intake Form)

ON PROBATION? YES / NO COUNTY_____
☐ Misdemeanor Court ☐ Felony Court

Does Client Qualify for Sliding Fee Scale? YES / NO →→ If YES, CO-PAY OF $_____ PER SESSION
If No, reason? _____
Payment Due At Time Of Session