Eric O. Emerson Counseling & Consulting Services

Sliding Fee Scale Evaluation

Date: _____

Patient Name: _____ DOB: _____

Spouse Name: _____ DOB: _____

Responsible Party: _____ DOB: _____

Address : _____

Telephone Home: _____ Cell: _____

Employer Name: _____

Address: _____

How long employed: _____ Monthly Gross Income: _____

Previous Employer (if less than 2 years) : _____

Address: _____

Spouse Employer Name: _____

Address: _____

How long employed: _____ Monthly Gross Income: _____

Previous Employer (if less than 2 years) : _____

Address: _____

Additional Income Source:_____ Monthly Gross Income: _____

Total Monthly Household Income: _____

Monthly Expenses

Number of Children/Dependants _____

Rent/Mortgage _____

Utilities Total / Average per Month _____

Health Care Coverage Deductions _____
Health Care Company _____

Child Care Costs _____

Adult Care Costs _____

Any special expenses or circumstances to be considered?

_____

Signature of person submitting this financial information:

_____

Thank you for taking the time to fill out our simple evaluation form.
It is our intention and common practice to be fair to all of our clients.
Your information will remain confidential, as will our counseling services for you or your family member.
If you have any questions, I may be reached at (520) 275-2233 or emailed at sandy@ericemersoncounseling.com .

Respectfully yours,

Sandy Emerson
Practice Administrator

Please submit by Fax (866) 824-9980 or Email sandy@ericemersoncounseling.com
Thank you!