Eric O Emerson Counseling & Consulting Inc.

Eric O Emerson MA.Ed.LISAC

Sliding Fee Evaluation

Date: _____

Patient Name: _____ DOB: _____

Spouse/Domestic Partner Name: _____ DOB: _____

Responsible Party: _____ DOB: _____

Address: _____

Telephone # _____

Employer Name: _____

Address: _____

How long employed _____ Monthly Gross Income _____

Previous employer (if less than 2 years) : _____

Address: _____

Spouse/Domestic Partner employer: _____

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: $ _____

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Sliding Fee Evaluation
Monthly Expenses

Number of children/dependents _____

Mortgage/Rent _____

Utilities total / average per month _____

Health care coverage costs _____

Health Care company _____

Child care costs _____

Adult care costs _____

Any special expenses or circumstances to be considered?

_____

Signature of person submitting 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 and to do everything possible to make your mental health care a priority. 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.

Respectfully yours,

Sandy Emerson

Practice Manager

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