LifePointe Counseling, LLC

Healing Hearts ✧ Restoring Hope

Financial Disclosure

Patient's Name:_____ Patient's Date of Birth: _____

GUARANTOR INFORMATION

Guarantor Name:_____ Relationship: _____

Address: _____ Home Phone: _____

City:_____ State:_____ Zip: _____ Work Phone: _____

# of family members claimed on most recent Federal Income Tax Return: _____ Cell Phone: _____

E-mail Address: _____ Social Security #: _____

INCOME

Gross Yearly Household Income: Please include income from all members that live in the same household and all forms of income (work, alimony, child support, dividends, etc.) $ _____.____

Other household financial resources (stocks, savings, inheritance, etc.) $ _____.____

ATTACHMENTS

Please include: ◆ Most recent W-2 form(s) and/or ◆ Most recent paycheck stub(s)

MISCELLANEOUS

Please include any other financial information that would be of importance in consideration of your request for a reduced fee:

_____

_____

_____

_____

I attest that the information disclosed above is true and accurately reflects my current financial situation. I further attest that I do not have any mental health benefits through any insurance plan for the treatment I receive at LifePointe Counseling, LLC. I authorize LifePointe Counseling, LLC to obtain credit reports or other financial confirmation as they deem necessary to verify financial need. If my financial status changes or I obtain insurance coverage, I will immediately notify LifePointe Counseling, LLC. I further acknowledge that I must update my information every six months for consideration of continued reduced fee services.

Guarantor's Signature: _____ Date: _____

STAFF USE ONLY

Provider:_____ Acct. #: _____ Amount Approved

Reviewed by: _____ Date: _____ $_____