

**Family and Child Treatment of Southern Nevada  
Financial Information for Services**

Name: \_\_\_\_\_ Social Security# \_\_\_\_\_

Parent Name (if client a child): \_\_\_\_\_

Intake Date: \_\_\_\_\_ Therapist: \_\_\_\_\_

Are you/child a victim of crime?      Yes      No

Have criminal charges been filed?      Yes      No      (Please provide information)

Type of Service - Please check

\_\_\_\_\_ Individual Child      \_\_\_\_\_ Individual Adult      \_\_\_\_\_ Family/Couple

Family income -	\$10,000-\$15,000	\$15,001-\$25,000	\$25,001-\$35,000
Family fee scale -	\$10 per session	\$20 per session	\$30 per session
Family income -	\$35,001-\$50,000	\$50,001 - above	
	\$50 per session	\$75 per session	

\$20 co pay - Insurance

Victim of Crime/Victim Witness

**Do not accept** MEDICAID, SIERRA HEALTH, HPN

If applicable - fill out and submit the enclosed VC/VW forms to qualify for no cost counseling. Please provide copy of pay or income stub, drivers license and insurance information, copies of any referrals.

I agree to pay \$ \_\_\_\_\_ for FACT professional services at the time rendered.

**Please read, initial & sign attached form.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are unable to pay for services rendered, please indicate and reason: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## AGREEMENT

- \_\_\_\_\_ I understand FACT's cancellation policy and agree to pay a fee equal to my assessed fee for each missed appointment and/or each appointment canceled with less than 24 hours notice. I further understand that if I am eligible for Victim's compensation and miss an appointment without proper notice, I will be charged my assessed fee.
- \_\_\_\_\_ I understand that there will be a return check charge of \$10.00 for each check returned to FACT.
- \_\_\_\_\_ I understand that if reports or letters are prepared by a FACT therapist. I will be responsible for payment for preparation at the same rate as my hourly counseling rate. This fee must be paid entirely before a report will be released. Court testimony will be billed at \$100.00 per hour.
- \_\_\_\_\_ I understand that I am responsible for any charges incurred while in counseling at this office. Payment is expected when services are rendered. My insurance will be billed as a courtesy but I am ultimately responsible for all charges incurred even in the instance that my insurance does not reimburse FACT.
- \_\_\_\_\_ I understand that FACT may provide information to or receive information from any insurance carrier, third party provider or provider of funding for services including Clark County Victim Witness and Nevada and other State Victims of Crime Programs for the purpose of determining eligibility or coverage or for processing claims and billings.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

FACT Representative \_\_\_\_\_

Date \_\_\_\_\_