Compass OF CAROLINA™

Family Counseling Client Assessment Form

Instructions

1.) Make sure all spaces are filled in. **Failure to do so will result in your paperwork being returned to you for completion.**

2.) Each person attending the counseling sessions must complete the FCD Client Assessment form and attached problem survey. **Please make sure that if this is counseling for a minor child that ALL paperwork is completed (adult paperwork included).**

3.) Complete the financial information and enclose a copy of your pay check stub(s), unemployment pay stub, tax return, and/or food stamp reimbursement as proof of income for the sliding fee scale. If you're not able to return this information with the paperwork, it will be returned to you for completion.

Insurance

If you have insurance, please fill out the insurance information and enclose a copy of your insurance card (front and back). If you're not able to return a copy of your card with the paperwork, you must bring it to your first appointment.

Court Ordered Counseling

If this is a court ordered counseling, please be sure to enclose a copy of the court order and/or DSS treatment summary with your application. **NOTE: your application will be considered incomplete until we recieve a copy of this order.**

Please return all forms to compass of Carolina in the envelope provided. If you have any further questions, please feel free to call Stacey Spurgeon at (864) 626-0561 or from outside Greenville at 1-800-203-9692

NOTE: You will be required to pay before each appointment, including your first session. During your telephone interview, you were given an estimate as to what your fee may be, so please be prepared to pay. Your fee will be officially set at your first appointment by the intake specialist.

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Please fill out the following information:

Name: ______________________ Today's Date: ______________________

Address: ______________________ Date of Birth: ______________________

Age: __________ Social Security Number: ______________________

Email Address (for follow up purposes): ______________ Years of Education: ______

Phone: __________ Work Phone: __________ Alternate: __________

Occupation: ______________________ Employer: ______________________

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Marriage Date: ______________ Divorce Date: ______________

Optional Information:

Gender:

- ☐ Male
- ☐ Female

Race: ______________ Religious Preference: ______________

Language: ______________

Number of people in your household: ______ Adults: ______ Children: ______

Please list the following information about each person in your household:

Name	Sex	Relationship	Age	Years of Education	Marital Status	Employer

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Insurance Information:

Primary Care Physician (PCP): ____________________ Phone Number: ____________________

Name of Insurance Company ____________________ PhoneNumber: ____________________

Please complete the following if you are insured by another individual's policy * A copy of your insurance card must be provided*

Full Name of Insured: ____________________ Relationship to Client: ____________________

Address: ____________________ Phone Number: ____________________

Social Security Number: ____________________ Employer: ____________________

Insured's Date of Birth: ____________________

For Office Use Only

Verification of Benefits

Date Contacted: ____________________ Phone Number (if different from above): ____________________

	Yes	No		Yes	No
Mental health Benefit:	☐	☐	PCP Referral Needed:	☐	☐
Pays for LMSW/LPC:	☐	☐	Deductible:	☐	☐
Pre-cert Required:	☐	☐	Co-pay:	☐	☐

Of Covered Visits: __________

Co-pay:

If Yes: Amount: $__________

Deductible:

If Yes: Total Amount: $__________ Amount Paid: $__________

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Emergency Information:

1.) Do you have any emergency health care needs we should be aware of: ☐ Yes ☐ No

If yes please specify: ______________________

Doctor's Name: ______________________ Phone: ______________________

2.) Who would we contact if we in case of an emergency? ______________________

Relationship: ____________ Home Phone: ____________ Work Phone: ____________

3.) Do you presently receive any public assistance? ☐ Yes ☐ No

What is your gross income?

Annually: ______________________ (or) Monthly: ______________________

(or) Weekly: ______________________ (or) Bi-weekly: ______________________

4.) What do you see as the major problem/issue?: ______________________

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5.) Please include any additional information you feel would be helpful: ______________________

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Thank you for taking your time to complete this form. The information contained will assist Compass of Caorlina in guiding you to the best resolution for your individual needs. If you have any questions or concerns, please ask your therapist. Compass of Carolina's therapist's strive to provide the best service for you and your family. We are glad to be able to serve you in any way we can.