

WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.

Client Information – Sliding Scale

Client Name: _____

If Minor, Parent/Guardian: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Client's Social Security #: _____ **DOB:** _____

Marital Status: _____ **Gender: Male** _____ **Female** _____

Home Telephone #: _____ **Other #:** _____

Referred by: _____

Employer: _____

Telephone #: _____ **May we call you at work?:** _____

Address: _____

Person to Contact in Emergency: _____ **Phone:** _____

Payment Information

Please read and sign below

I have discussed the rate per session with my counselor or other staff member and I agree to pay the per session rate specified. Fees are payable at the time of service.

To better serve our clients, 24 hours notice of the cancellation of an appointment is required. Without notice a \$25.00 charge will incur immediately and possibly forfeiture of any specific appointment time slot.

Client or Guardian Signature

Date

Per-Session Rate: \$ _____ Authorized Signature: _____

Therapist: _____