McCaskill Family Services, PLLC

409 Plymouth Road, Suite 250, Plymouth, MI 48170
2040 Grand River Annex, Suite 300, Brighton, MI 48114
734-416-9098, Ext. 1 • www.mccaskillfamilyservices.com • office@mccaskillfamilyservices.com

Name: _____

Today's Date: _____ Birth Date: _____

How did you hear about our Parenting Drop-In? _____

Address: _____ City: _____ Zip: _____

If necessary, I give McCaskill Family Services permission to call me at the following numbers:

Home Phone# _____ OK to leave a message: Yes No
Work Phone# _____ OK to leave a message: Yes No
Cell Phone#_____ OK to leave a message: Yes No
Alternative Phone# _____ OK to leave a message: Yes No

Marital Status of parents: _____
IF parents are separated/divorced, how old was child at time of separation? _____

List all people living in household:

Name	Relationship	Age

If any children are living outside the home, please list names and ages:

_____ _____
_____ _____
_____ _____

Please flip over and complete back side of form.

CONFIDENTIALITY

Any information that you provide, as well as counseling and/or records that are maintained, are kept strictly confidential, with the exception of life threatening situations, cases of suspected child abuse, when release is otherwise required by law, or when you request that the information be released. Should the need arise; your case may be discussed anonymously during case consultation with another licensed psychologist while keeping identifying information strictly confidential.

PAYMENT OF FEES

It is customary to pay for professional services when they are rendered, preferably by cash or check made payable to MFS.

CHARGES

Charges for professional services are as follows:
Initial Clinical Interview (Therapy, First Session): $150.00-$225.00
Individual and Family Therapy (Per 45-Minute Session): $75.00-$195.00
Parenting Drop-In Group (Per Meeting): $55.00
Record Review (Academic, Clinical, etc., per hour): $150.00
Telephone/E-Mail Communication (per 15 Minutes): $50.00

INSURANCE

Many insurance plans cover all or part of the costs of psychological services. If you expect to file for reimbursement from your insurance company, we will, at your request, provide you with a suitable receipt. Submission of forms or receipts to the insurance company, is in all cases, the client's responsibility.

Please indicate that you have read the above statements by signing below:

Signature: _____

Printed Name: _____

Date: _____ **SSN#: _____**