

Wonders Counseling Services, LLC

Reduced Fee Application and Agreement for Individual Counseling

Date: _____ Client's name: _____

Person responsible for payment: _____

Total Gross monthly household total income: _____

Total monthly household total expenses: _____

Adjusted gross annual income for past two tax years (from IRS tax return form): _____

Reduced Fee Amount Requested: \$85 \$100 \$115

Reason(s) for requesting reduced fee: _____

To be filed out by the counselor:

Date of application review _____ Accept ___ or Deny ___ Reason if denied _____

Reduced Fee Amount: \$85 \$100 \$115

Dates of Reduced Fee Approval coverage: _____

Scheduled review date: _____

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### Agreement

I have had an opportunity to discuss my financial concerns with my counselor and understand that I must agree to the following stipulations in order to receive this reduced fee designated above until the above-noted scheduled review date:

- I will provide my counselor no less than 24 hours notice in the case of cancellation or rescheduling of an appointment and if I fail to provide such notice I authorize my credit card on file to be charged the full reduced fee rate. I understand that if I miss more than one session without providing 24 hours notice I will be charged the full rate of \$135
- I agree to provide my counselor with honest and timely update if my financial situation improves prior to my review date and will pay more toward my fee when and if I can afford to pay more.

Client Signature/Date: \_\_\_\_\_

Counselor Signature/Date: \_\_\_\_\_