



## Sliding Scale Agreement

In an effort to provide psychotherapy and coaching to more individuals of all economic means, Reflective Counseling offers a limited number of sliding scale options for individuals in need. Financial need is self-assessed. I understand that Reflective Counseling's fee for a 50-minute initial evaluation/consultation is \$200 and follow-up therapy sessions are 50 minutes and billed at \$180. Usual and customary coaching sessions are 50 minutes and billed at \$180.

\_\_\_\_\_ (initial)

I am electing to request a reduced session rate due to financial hardship and lack of or insufficient insurance coverage. I further understand this offer is valid so long as I maintain regularly scheduled appointments – at least twice monthly, and am current with my payment.

\_\_\_\_\_ (initial)

I am also aware I may be able to request a shorter session duration, as clinically determined by your clinician at a reduced rate (to be discussed after initial on-boarding and treatment). I request to pay a reduced fee of: \$\_\_\_\_\_ per session/week/month (circle one). I understand that this reduced rate is good for 1/3/6 months, and will expire on \_\_\_\_\_.

\_\_\_\_\_ (initial)

Upon expiration, I may renegotiate a rate for services based on my financial status and Reflective Counseling practice's availability. I further understand I may lose my reduced rate should I take a break from sessions, attend fewer than two (2) sessions per month, or miss a payment. The reduced rate option is contingent upon my financial means and the fee agreement will become null and void when my financial status improves.

\_\_\_\_\_ (initial)

I agree to notify my clinician immediately as my financial status improves, so that a new agreement can be reached. My signature indicates that I have reviewed and understood the terms and conditions of the Sliding Scale Program.

\_\_\_\_\_ Name of Client (printed), Date

\_\_\_\_\_ Signature of Client, Date

By typing my name, and checking this box, I confirm that I am authorizing this form.

\_\_\_\_\_ Clinician Signature, Date