

**Cary Office (main):** 130 Preston Executive Drive., Suite 202, Cary NC 27513  
**Raleigh Office:** 9207 Baileywick Road, Suite 203, Raleigh, NC 27615  
**Greensboro Office:** 2709-B Pinedale Rd, Greensboro, NC 27408

**Telephone:** (919) 467-7777

**Reduced Fee Application**

|   |                 |  |
|---|-----------------|--|
| Date:   | Name of Client: |  |
| Phone:  | Email:          |  |
| Name of Parent(s) (if applicable):  |                 |  |
| Name of Clinician:  |                 |  |
| Service requested: <input type="checkbox"/> Therapy <input type="checkbox"/> Testing<br>(Please describe testing package) |                 |  |
| Reason for requesting services?   |                 |  |
| Income level of household?<br>(Verification of income may be requested.)  |                 |  |
| Other financial burdens?  |                 |  |

Please note:

- **Reduced fee does not apply to first intake/consult appointment.**
- Therapy services require weekly or every/other week attendance to qualify for the reduced fee. If attendance becomes less frequent, we will revert to regular therapy rates.
- Therapy clients must also agree if financial circumstances change (i.e., insurance benefits change, someone gets a raise or a job), you notify us and regular therapy rates will apply to future sessions.
- Reduced fees are meant to be temporary. A new application will be required every 3-6 mos.

I agree the information reported in this application is accurate and can be verified upon request. I agree to attend weekly or every other week appointments in therapy. I understand I will no longer qualify for the reduced fee rate if attendance is less frequent. I also agree to notify my psychologist if my financial circumstances improve.

\_\_\_\_\_  
Signature of client (or parent)

\_\_\_\_\_  
Date

|                              |                |
|------------------------------|----------------|
| Approved by/Clinician notes: | New Fee:<br>\$ |
| Application valid until:     |                |