515 E Crossville Rd
Suite 210
Roswell, GA 30075
Phone: 678-538-7823

REDUCED FEE AGREEMENT

This agreement is for patients in need of a reduced fee due to financial hardship. Little Futures has a limited number of scholarships to help members of the community in times of need. Therapists are ethically bound to document the reason for this accommodation and to revisit the agreement on a regular basis. Please know that this is not intended to be intrusive but to support the justification why one client may be paying less for the same services as another.

Please provide the necessary information and your signature with today's date as indicated below. Should your situation change prior to the date indicated below, it would be much appreciated for you to let your therapist know as soon as possible so that your scholarship may be passed on to someone else in need.

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I, _____ (patient/patient's guardian), hereby request a scholarship from Little Futures by reducing the usual fee of $_____ for a 50-minute appointment to the reduced rate of $ _____ for the following reason(s):

OR

I, _____ (patient/patient's guardian), hereby request a scholarship from Little Futures by reducing the usual fee of $_____ for an evaluation to the reduced rate of $ _____ for the following reason(s):

____ I and/or someone in my family who helps pay our expenses has incurred unforeseen expenses recently, and I/we need time to catch up. These expenses were for: _____
_____

____ I or someone in my family who helps pay our expenses is receiving reduced pay for the following reasons: _____

____ I or someone in my family who helps pay our expenses is without employment at the moment, and I/we agree to work toward finding employment.

____ I or someone in my family who helps pay our expenses is ill and cannot work.

____ Other reason. Please describe: _____
_____

Your signature below indicates that you understand that this agreement will be reviewed on a quarterly basis to determine if you are still in need of financial assistance. You also understand that the scholarship is based on true need as well as "on your honor" to make this determination and communicate it accurately to your psychologist.

This Agreement will be reviewed three months from today's date which is _____.

Patient's Signature (If appropriate)_____Date: _____

Parent's/Legal Guardian's Signature:_____ Date: _____

Psychologist's Signature:_____ Date: _____