ATLAS COUNSELING, LLC

Financial Assistance Form

Name: _____ Date of Birth: _____

Please indicate your need by checking yes/no in the boxes below.

Yes	No	
☐	☐	Fees would create a financial hardship for me/my family.
☐	☐	I am requesting reduced fees for psychotherapy services.
☐	☐	I understand that the reduced fee schedule is time-limited and will be reevaluated in 3 months

Revised Fee Schedule:

Initial Session: _____ 55 min Session: _____

Start Date: _____ End Date: _____

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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