740 East 52nd Street, Suite 9
Indianapolis, IN 46205
317-455-LMHC

Fee Reduction Contract

It is important to me that quality therapeutic services are available to those who truly desire more whole-hearted living and conscious relationships. As such I am willing to offer a reduced fee based on annual household income as set out in the table below

Annual household income	Household members					
	1	2	3	4	5	6+
$120,001 and above	-	-	-	-	-	15%
$100,001 - $120,000	-	-	10%	15%	20%	25%
$90,001 - $100,000	10%	15%	20%	20%	25%	30%
$80,001 - $90,000	15%	20%	25%	25%	30%	35%
$70,001 - $80,000	20%	25%	30%	30%	35%	40%
$60,001 - $70,000	25%	30%	35%	35%	40%	40%
$50,001 - $60,000	30%	35%	35%	40%	40%	45%
$40,001 - $50,000	35%	40%	40%	45%	45%	45%
$30,001 - $40,000	40%	40%	45%	45%	50%	50%
$30,000 and below	45%	45%	45%	50%	50%	50%

Further reductions cannot be negotiated. It is considered unethical in my profession to do so. By signing this contract you are agreeing that this reduction applies to my hourly rate of $150 and no further reductions will be made or requested. To qualify for this reduction this form must be completed in full and **financial documentation must be submitted. This documentation includes income tax returns (to be updated annually);** 2-3 check stubs may also be requested. Other documentation that may be considered would be a contract or job offer letter from your employer, documentation from the unemployment office, etc. Please note that updated tax returns must be submitted each year.

If this scale changes, you will be provided with written notification at least 30 days in advance. Payment is expected prior to all scheduled meetings. Phone calls lasting less than ten minutes are normally not billed. However, if more than ten minutes per week is spent on the phone, receiving phone messages, or reading and responding to emails, this time will be billed on a prorated basis. Other services subject to prorated fees include, but are not limited to, court testimony, report writing, or communicating with others at your request.

By signing this contract, you are stating that you are requesting and agreeing to these terms voluntarily. You agree to hold Brooke Randolph, LMHC, and Brooke-Randolph, LLC free from any liability including loss of income, loss of property, or financial responsibility for injuries incurred, regardless of whether injuries occurred in or around the office space utilized. You understand that you responsible for any choices you make that are directly or indirectly related to services received. No assumption of responsibility is made, or given, and you agree not to hold Brooke Randolph, LMHC responsible or liable in any form or fashion, for such actions taken of your own accord. By signing this agreement, I acknowledge the following conditions and release Brooke Randolph, LMHC, and Brooke-Randolph, LLC, from all liability related to any claims or litigation arising directly or indirectly from my participation in counseling services. You can choose to terminate services at any time.

Please list all members of your household

Name	Age	Relationship to you	Annual Income

Any other dependents? ____

Are you a student? ____________ If yes, where ____________________________________

By signing below, I indicate that I agree to all terms as listed in this contract and all information provided is true, accurate, and up to date.

Signed: ____________________________________ Date: ____________________

Name: ____________________________________ Date of birth: ________________

Mailing Address: ____

Social Security Number:____

Office Use Only

Financial documentation submitted: ____

Date: ____________ Annual Income: __________________ Household members: __________

Student verification documentation: ____

Date: ______________

Licensed Mental Health Counselor