



SLIDING SCALE INFORMATION

Complete form and bring proof of income information and last years tax return to the FIRST Session

List ALL income producing adults in the household.

Note: If client is a minor child, please indicate the adult relationship.

Household Address _____

City/St/Zip _____ Phone# (____) _____

Adult #1

Name: _____ Relationship to child _____

Work# _____ Employer: _____ Occupation: _____ Annual Income _____

Adult #2

Name: _____ Relationship to child _____

Work# _____ Employer: _____ Occupation: _____ Annual Income _____

Adult # 3

Name: _____ Relationship to child _____

Work# _____ Employer: _____ Occupation: _____ Annual Income _____

Total Number of People living in Household? _____

Total Annual Household Income: _____

Parent/Guardian/Client Signature _____ **Date:** _____

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Office Use Only:

Based on the information provided the Sliding Scale Fee is \$ _____.

This fee will be paid at each therapy session attended.

Responsible Party Initial indicates acceptance of sliding scale fee and payment _____.

Olive Branch Counseling Center, Inc. Representative Initials _____.