

SLIDING SCALE FEE AGREEMENT

I, _____ (*client's name*), certify that I do not have health insurance [or certify that I cannot utilize health insurance for services rendered by _____ (*therapist/practice*)] and/or that due to my current financial situation, I cannot afford the full fee rate of \$ _____. I therefore request that my fee be adjusted.

My current monthly income is currently insufficient to cover my monthly expenses and therapy at the rate of \$ _____. This is also true of my total household income, if living with a partner. Therefore, I understand that the fee for services with _____ (*therapist/practice*) will be \$ _____ per session and is payable at the time of each session, unless other arrangements are made in advance.

I further understand that I will not be charged for any appointments that I cancel at least ___ hours in advance. Additionally, I understand that appointments I do not cancel at least ___ hours in advance are subject to a "Late Cancellation" charge. I am solely responsible for these charges as they apply, as well as the costs associated with collecting these charges.

I agree to notify _____ (*therapist/practice*) of any substantive changes in my financial situation (such as increase or decrease in my income) within ___ days of the change, and understand the fee may change according to my updated financial situation. I further acknowledge that my therapist will periodically verbally review my financial status with me, in order to reassess eligibility.

A continuance of Sliding Scale benefits is not guaranteed and is subject to modification and/or elimination at the sole discretion of _____ (*therapist/practice*).

Client Printed Name Date

Client Signature

Therapist Printed Name Date

Therapist Signature

SLIDING SCALE FOR THERAPEUTIC SERVICES

Fees are effective as of _____ (date) and are adjusted periodically.

Standard Fees

| Services | Intern | Mental Health Practitioner | Licensed Mental Health Professional |
|---------------------------------------|----------|----------------------------|-------------------------------------|
| Intake (45-50 min) | \$ _____ | \$ _____ | \$ _____ |
| Individual, couple, or family session | \$ _____ | \$ _____ | \$ _____ |
| Extended session (75-80 min) | \$ _____ | \$ _____ | \$ _____ |
| Short session (25-30 min) | \$ _____ | \$ _____ | \$ _____ |
| Group therapy session | \$ _____ | \$ _____ | \$ _____ |
| Other Services _____ | \$ _____ | \$ _____ | \$ _____ |

Sliding Fee Scale

The sliding fee scale is available for all cash clients seeing intern, mental health practitioner, or licensed mental health professional

| Annual Income | Intern | Mental Health Practitioner | Licensed Mental Health Professional |
|---------------------|----------|----------------------------|-------------------------------------|
| <\$20,000 | \$ | \$ | \$ |
| \$20,000 - \$35,000 | \$ | \$ | \$ |
| \$35,000 - \$50,000 | \$ | \$ | \$ |
| \$50,000 - \$60,000 | \$ | \$ | \$ |
| \$60,000 - \$70,000 | \$ | \$ | \$ |
| \$70,000 - \$80,000 | \$ | \$ | \$ |
| >\$80,000 | \$ _____ | \$ _____ | \$ _____ |

The following conditions apply to reduced fees:

- Sliding fee scale is based on the average family of 2-4 people and can be adjusted higher or lower based on the number of people living in the home.
- Fees agreed upon under previous sliding fee scale charts will remain in effect and be honored for the duration of client's time.
- Other extenuating circumstances regarding the client's ability to pay, such as high medical bills, can be taken into account when agreeing up on a fee.