

FEE WORKSHEET

Washington State University (WSU) Psychology Clinic
P.O. Box 644820
Pullman, WA 99164-4820
509-335-3587 Fax: 509-335-1030

Client Name: _____ **Client #:** _____
Parent/Guardian/Authorized Adult: _____ **Relationship to Client:** _____

The WSU Psychology Clinic provides therapy and assessment services on a sliding scale fee that is based on your household income or your status as a full-time student (Please see fee charts on the back of this handout). We do not submit claims to third-parties such as health plans or insurance companies for services we render to clients. More specifically, the Psychology Clinic is not enrolled or contracted with Medicare, Medicaid (including Medicare Advantage or Medicaid Managed Care Organization plans), or any other Federal health care program. The Psychology Clinic is neither permitted to bill Federal health care programs nor are you permitted to seek reimbursement for the services received at the Psychology Clinic. Each client or their guarantor (e.g., parent or guardian) is generally required to pay out of pocket (i.e., cash pay) for the mental health services received at the Psychology Clinic.

Although we do not bill insurance, we are required to note the insurance status of our clients.

Do you have health insurance? Yes No
o **If yes, do you have:** ___ Medicaid ___ Medicare ___ Tricare ___ Private Health Plan (Regence, Aetna, Kaiser) ___ Other: _____

Clients with Health Insurance: If you have health insurance through a Federal health care program (e.g., Medicare, Medicaid, Tricare, etc. or their contracted managed care plans) or other health insurance, you may be able to get mental health services fully covered by those programs/plans by receiving treatment at a provider enrolled/contracted with those programs/plans. If you have health insurance, you can reach out to your health plan and identify providers delivering covered services for their insureds.

Proof of monthly/annual net income or student ID is required at the time of the intake interview if you wish to be considered for the sliding scale fee. We will not keep a copy of these documents but your therapist will verify your income. If you do not provide proof of income or student status you will be charged at the highest rate for services.

Note: All confidential information on your income document should be redacted (e.g., marked out with heavy black ink) before the therapist views it. This includes social security number, bank account numbers, etc.

Fees are due at the time services are rendered. In cases of extreme financial hardship, lower fees may be negotiated on a temporary basis with the approval of the Clinic Director. Please discuss this process with your therapist

Fee Agreement:

I, _____, the Client (or Parent/Guardian/Authorized Adult), request that the Psychology Clinic provide professional services to me or my child/ward, and I agree to pay the fee of \$ _____ per hour (or \$ _____ flat assessment rate) for these services. I acknowledge that I am personally responsible for these professional fees for services provided by the Clinic to me or my child/ward.

Client Signature (or Parent/Guardian/Authorized Adult if Client is under the age of 18) **Date**

Therapy Services

Student Fee: Fulltime students are eligible for a lower fee of \$10/hour.

Community Members Sliding Fee Scale: Please circle your monthly or annual income and family size (include yourself and all dependents) on the chart below:

Number of Family members and Rate per hour			
Monthly income	Annual income	1 -2	3+
0-3,750	0-44,999	20.00	15.00
3,751-7,083	45,000-84,999	50.00	40.00
7,084 +	85,000 +	80.00	60.00

Intake interviews are scheduled for 2 hours and will be charged at two times the established fee for sessions.
2 missed appointments in a row or less than 80% attendance may result in termination of sessions.

Assessment Services

Please circle your monthly or annual income and the type of assessment you are seeking on the chart below. **Note:** \$50.00 fee per additional area assessed.

Assessments	Annual Income		
	\$ 0-44,999	\$45,000-84,999	\$85,000+
Learning Disability	\$350.00	\$450.00	\$550.00
Attention Deficit/Hyperactivity	\$350.00	\$450.00	\$550.00
Autism Assessment	\$350.00	\$450.00	\$550.00
Intellectual Ability	\$350.00	\$450.00	\$550.00
Neuropsychological	\$350.00	\$450.00	\$550.00
Psychological Evaluation/Diagnostic Clarification	\$250.00	\$350.00	\$450.00
Intake appointments Fee (included in total fee listed above)	\$25.00	\$25.00	\$25.00

Staff use only

Verification of Income:

Document Viewed: ___ Income Tax Return for the Year ___ Annual Income: _____
___ Other (Please specify: _____)

Name of Person Verifying Documentation: _____

Signature of Person Verifying Documentation: _____

Date of Verification: _____