

FairView Counseling and The Play Therapy Center
Financial Contract and Policy

Client Name _____ Client # _____ Date _____

FOR CLIENTS UTILIZING FAIRVIEW COUNSELING’S SLIDING FEE SCALE

Please provide the following information so we may set your fee accordingly.
Verification of income is required at the initial session or full fee will be charged. If there is a change in your financial situation, please contact our office manager so that your information can be updated.

Name of Household Member (List ALL members of household regardless of income)	Relationship to You	Gross Income (before deductions)
	Self	\$ <input type="checkbox"/> weekly <input type="checkbox"/> yearly
		\$ <input type="checkbox"/> weekly <input type="checkbox"/> yearly
		\$ <input type="checkbox"/> weekly <input type="checkbox"/> yearly
		\$ <input type="checkbox"/> weekly <input type="checkbox"/> yearly
		\$ <input type="checkbox"/> weekly <input type="checkbox"/> yearly
		\$ <input type="checkbox"/> weekly <input type="checkbox"/> yearly

Do you receive child support and/or alimony? Yes No. If Yes, amount per week \$ _____

Do you pay child support and/or alimony? Yes No. If Yes, amount per week \$ _____

Do you receive unemployment compensation? Yes No. If Yes, amount per week \$ _____

Do you receive any other income?(worker’s compensation, social security, etc.) Yes No
If Yes, amount per week \$ _____

The mission of FairView Counseling and The Play Therapy Center is to foster the health and welfare of children by providing affordable counseling and educational services to children, their families, and the community members who directly affect their lives. Client fees are an important source of income to continue our purpose. Failure to uphold your financial responsibility impacts on the lives of others.

Payment for services is due at the time of service. We accept cash, check, MasterCard/Visa.

I understand FairView Counseling’s Policy that:

- 1) **24 hours notice is required for cancellation; otherwise a \$40 fee will be charged.** This same fee applies to missed appointments.
- 2) Fee incurred for checks returned from the bank for any reason is the client’s responsibility.
- 3) If I have not been active in therapy for a period of (3) months, my case will be terminated. If I wish to return after I have been terminated, I can call and request to be set up for a new intake session.

I agree to pay the sliding scale rate of \$ _____ for the initial evaluation and \$ _____ for weekly therapy sessions. I understand that this rate will be reviewed periodically and could increase or decrease depending on my financial situation. FairView Counseling has the right to increase the overall sliding fee scale on a yearly basis.

CLIENT NAME

CLIENT or PARENT/GUARDIAN SIGNATURE

DATE

Copy Given to Client _____