CLIENT: _____

FEE SCHEDULE
GROUP / CAMP

Fees are based on a 50-minute hour. Assessment and initial therapy appointments often require two to three hours per session. Standard fees are as follows:

Social Skills Group	$100 per session for 10 or 20 week child group
APEX Booster Program	$85 per session
APEX Summer Camp Program	*Fees determined annually; early registration discount. See www.apex.edu for details.

Deposits
A prepayment may be required for some services.

Billing
Client accounts are closely monitored. You will receive a statement for services provided during the prior month. If timely payments are not submitted, or if you do not initiate an agreement to develop a mutually acceptable payment plan, your account will be forwarded to a collection agency. Services may be discontinued and reasonable late charges, interest, and applicable attorney fees may be imposed upon delinquent accounts by the collection agency. The UW Autism Center requests that the person responsible for the bill provide the last 4 digits of their social security numbers to verify identity. For questions regarding deposits or general billing issues, please contact our billing coordinator, at 206-616-2754.

Cancellation Policy
All confirmed appointments require **at least 24 hour advance notice for cancellation. If we do not receive 24 hour notice, you will be billed at the standard rate for that session.** In addition, you will be billed for all no-show appointments. Insurance companies generally do not reimburse for missed appointments.
Exceptions may be made in the case of illness or family medical emergency.

Family Scholarship Fund
The UW Autism Center has established a Family Scholarship Fund (FSF) to qualifying families receiving services from the UW Autism Center. Families whose income falls within the parameters of the FSF may qualify for reduced service fees on a first come, first served basis. This scholarship funding is not retroactive; the use of funds may only be applied toward services provided after the date of approval. The FSF program is always subject to available funds. Families are required to pay at time of service for non-covered services. Please consult a UW Autism Center staff member for further information or a FSF application.

Ben's Fund
Ben's Fund may be available through FEAT of WA to provide grants to families to help them obtain treatment services. To find out if your family may qualify for an autism grant worth $1,000.00 per child, please go to this link: http://www.featwa.org/grants/ .

I, the parent/legal guardian/client, understand that: *(Please initial each box)*

_____ The UW Autism Center is not a contracted (preferred) provider with most insurance carriers.

_____ At this time, the UW Autism Center is not able to accept open medical coupons for SLP, and behavioral services. Medical evaluations and consultations by physicians may be covered by open medical coupons. For more information on UW Medical Center services call 206-987-8455.

_____ I am responsible for all charges for services provided to me and/or my child by the UW Autism Center..

_____ Many insurance companies do not cover ALL services provided by the UW Autism Center.

_____ For clients with non-contracted insurance carriers the submission of insurance claims is a courtesy service and does not relieve me of my financial obligation.

_____ Any lawsuit for collection of my account may be brought to King County, Washington.

_____ It is my responsibility to contact my insurance carrier to determine whether the services by the assigned provider meet the criteria for reimbursement.

_____ I must obtain any required pre-authorization and/or referrals required by my insurance carrier.

_____ It is my responsibility to contact the UW Autism Center Intake Coordinator at 206-616-8642 should I acquire open medical coupons, so that referrals may be provided.

Print client's name _____

Your signature below verifies that you have read this document and agree to its terms and agree to receive health care from the UW Autism Center. If any portion of this form is unclear, please consult with UW Autism Center staff prior to providing your signature.

_____

Signature **Date** **Printed Name**

If signed by person other than client, please specify your relationship to client: ☐Parent ☐Conservator