CLIENT: _____

FEE SCHEDULE
ABA SERVICES

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

	Therapy/Supervision	Assessment/ Evaluation	Program Development
Behavior and Education Consultant - BCBA	$152/hr.	$152/hr.	$152/hr.
Behavior Technician	$ 52 /hr. (2 hour minimum)	---	---

NOTE: The UW Autism Center contracts with several insurance companies. In the event that we do not have a contract or your insurance does not cover these services, clients may be billed based on the above standard rates.

Family Scholarship Fund is available. (Please see explanation below)

Billing:
Client accounts are closely monitored. You will receive a monthly statement for services provided during the prior month. For questions regarding deposits or general billing issues, please contact our billing coordinator, at 206-616-2754. If you pay by a check and it is returned for insufficient funds, we will expect a new payment in a timely manner and payment for any service charges levied for insufficient funds. In general, large balances should not accrue, and we will work with you to prevent this from happening. Services may be discontinued and reasonable late charges will be imposed upon unpaid balances. *As a last resort, we reserve the right to use a collection agency for large balances*.

Change in Insurance Coverage:
It is your responsibility to let the ABA Patient Navigator know when you have any changes made to your insurance coverage or policy. We are unable to provide services to families with certain insurance coverage (e.g., Medicaid).

Cancellation Policy:
All confirmed appointments require *24 hour advance notice for cancellation. If we do not receive notice that you are canceling or notice is less than 24 hours prior to the appointment, you will be billed at the standard rate for that session.* Please note that many insurance companies do not reimburse for missed appointments. *Exceptions may be made in the case of illness or family medical emergency.* New clients who have not yet been seen at UWAC and have more than one cancellation of or "no-shows" to intake appointments will be placed back at the bottom of the waitlist. Ongoing psychotherapy clients must attend regularly scheduled appointments. We reserve the right to discontinue services for any client who cancels more than 20% of scheduled appointments, even those due to planned vacations or illness.

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 <u>not</u> 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 support the cost of treatment services. Ben's fund will not pay for diagnostic evaluations. To find out if your family may qualify for an autism grant worth $1,000.00 annually per child, please go to this link: http://www.featwa.org/grants/

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

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

_____ I understand that some insurance companies do not cover some services provided by the UW Autism Center and it is my responsibility to contact my insurance carrier to determine whether the services by the assigned provider will in fact be covered.

Print client's name _____

Your signature below verifies that you have read this document, agree to its terms, and agree to pay for care received through 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 ☐Guardian