

CLIENT: _____

FEE SCHEDULE PSYCHOLOGY/PSYCHOTHERAPY SERVICES

Diagnostic Evaluation: The fee for our standard diagnostic evaluation is typically \$2,250-2,500. When additional services are necessary, this fee may increase. Families will be notified of any increase in advance. A deposit of \$300 or amount as designated by your insurance plan is required at your first visit. The insurance/CPT code for these appointments are 90791 and 96101.

Other Evaluations: In some special cases, when an ASD diagnosis has already been confirmed, our clinic offers evaluation of conditions often associated with autism. These are briefer in format and include the intake appointment plus 2-5 hours of assessment/report writing time.

Additional Fees

- Additional report writing; review of previous records; telephone or email communications exceeding 15 minutes; meeting attendance; and home, school, or therapy assistance will be billed when essential to therapy/evaluations or when requested by parent/client. These additional fees may not be reimbursed by insurance companies.
- All clinician travel time to home, school or off-campus locations for evaluations will be charged and billed to you directly and will not be billed through insurance.

Additional fees are charged at the hourly rate for evaluations:

Clinician	Assessment/ Evaluation	Travel Fees
Licensed Psychologist	\$225/hr.	\$112/hr.
Post-doctoral Psychology Fellow	\$125/hr.	\$65/hr.
Master's Degree level (including pre-doc intern)	\$100/hr.	\$50/hr.

Psychotherapy rates are as follows:

Clinician	Therapy/Consultation	Group Therapy
Licensed Psychologist	\$150/hr.	\$125/hr.
Post-doctoral Psychology Fellow	\$125/hr.	\$100/hr.
Master's Degree level (including pre-doc intern)	\$100/hr.	\$100/hr.

Fees are based on a 50-minute hour for individual therapy and 60-minute hour for group therapy. If psychotherapy sessions go more than 50 minutes, clients will be charged for the additional time.

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 your patient navigator. 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. Reasonable late charges will be imposed upon unpaid balances. In some cases, services may be discontinued. *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 billing department or patient navigator know when you have any changes made to your insurance coverage or policy. We are unable to provide services to families with some types of insurance.

Clients with Medicaid Coverage

The UW Autism Center is a Health Care Authority Center of Excellence for managed care plans; however, at this point in time, the UW Autism Center is not contracted with Medicaid. There will be no coverage under your Medicaid managed care plan unless your plan has entered into a single case agreement with the UW Autism Center to provide specified services. This will be determined on a case by case basis. The intake coordinator or patient navigator can provide information about pursuing a single case agreement. Please keep in mind that it is possible that you may be dropped off your Medicaid managed care plan unexpectedly. You need to verify your coverage with your managed care plan before the end of each month to make sure that you still have the same benefits through the following month. In the event there is a gap in coverage, it is possible that clinical services will be interrupted until such time as coverage is resumed. To avoid interruptions in services, you are encouraged to apply for supplemental funding, such as Ben's Fund. The intake coordinator or patient navigator can provide applications and more information about these programs.

Cancellation Policy:

All confirmed appointments require *24 hour advance notice for cancellation. If we do not receive at least 24 hour advance notice that you are canceling you will be billed at the standard rate for that session. Exceptions may be made in the case of illness or family medical emergency.* Please note that we cannot bill insurance companies for missed appointments. New clients who have not yet been seen at UWAC and have more than one cancellation or "no-show" to intake appointments will be placed back at the bottom of the waitlist. Ongoing psychotherapy clients must attend regularly scheduled appointments. In order to serve clients who are waiting for services, 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 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 Families for Effective Autism Treatment (FEAT) of Washington 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 unless insurance exclusions apply.
- _____ 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

Additional Services Agreement

(Please do not complete this portion prior to meeting with your clinician)

Please initial

☐ I agree to approximately _____ hours of additional testing, interpretation, and report writing for my assessment or my child's assessment.

I approve these additional services with (clinician name): _____.

Signature

Date

Printed Name

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