

SLIDING FEE SCHEDULE
Effective January 1, 2007

The UND Psychological Services Center is a non-profit agency staffed by student clinicians. Payment for services must be made at the time of service. Our affiliation with UND's Department of Psychology Clinical Training Program as a training center enables us to maintain a fee scale that makes our services accessible to the general public, and at significant cost reduction to other services in the area. Fees enable us to continue to provide services to the community.

INTAKE SESSION RATES: FREE (Includes some brief assessment measures for outcome purposes).

SERVICE FEE SCHEDULE:

Employment/Income	Service	Fee Schedule
UND Student	Individual/Couples/Family	\$5
UND Student	Group Therapy	\$15
UND Student	Assessment/Specialty	See schedule
UND Employee/Family	Individual/Couples/Family	\$5
UND Employee/Family	Group Therapy	\$15
UND Employee/Family	Assessment/Specialty	See schedule
Other	Individual/Couples/Family	Individual Therapy Rates
Other	Group	Group Therapy Rates
Other	Assessment/Specialty	Assessment Schedule Rates

INDIVIDUAL THERAPY RATES (and assessments for therapy):

Annual Gross Income*	Number of Persons in Household**				
	1	2	3	4	5+
\$0-5,000	\$5	\$5	\$5	\$5	\$5
\$5,001-10,000	\$10	\$9	\$8	\$7	\$6
\$10,001-15,000	\$15	\$14	\$13	\$12	\$11
\$15,001-20,000	\$20	\$19	\$18	\$17	\$16
\$20,001-25,000	\$25	\$24	\$23	\$22	\$21
\$25,001-35,000	\$30	\$29	\$28	\$27	\$26
\$35,001-45,000	\$40	\$38	\$36	\$34	\$32
\$45,001-55,000	\$50	\$48	\$46	\$44	\$42
\$55,001-70,000	\$60	\$58	\$56	\$54	\$52
\$70,001-99,999	\$70	\$68	\$66	\$64	\$62
\$100,000+	\$75	\$75	\$75	\$75	\$75

*Gross Income is the total earned income from salary of wage earners (income tax included) and/or net profits from business ventures such as farming.

** Number of persons in household refers to the number of persons depending on the household income, not roommates.

ASSESSMENT FEE SCHEDULE:

Assessment (includes Scoring, Report Writing & Feedback) Type	Billed at a rate of \$40/hour	
	Time	Cost
Intelligence	3	\$120
Academic	3	\$120
Personality	2	\$80
Battery (Combination)	6	\$240
Neuropsychological	10	\$400

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GROUP THERAPY RATES:

Group treatment fees are set at \$15 per session. A deposit of \$60 (or the cost of the last four visits) will be due upon the first group visit to a total of \$75.

ASSESSMENT SERVICES:

Assessment services are services that involved standardized protocols and assessment measures to further evaluate functioning in a variety of areas. At times, a client may be seen for therapy and assessment services may be warranted or recommended by the therapist. The therapist will inform the client of this recommendation and the separate billing of these service fees (i.e., not the same as therapy fees). A deposit of the cost for assessment services will be due upon the first assessment visit for a total cost deposit. If there is a financial issue, this should be directed to the Clinic Director via the therapist.

PAYMENT EXPECTATIONS:

Fees for services are required at the time of the appointment. Clients will receive a monthly statement of their fees and payments for their records. We do not bill insurance companies, however, these statements can be used to submit to your insurance claims department. Should the situation arise that a client is financially unable to afford the fee (i.e., loss of job), this concern should be raised with your therapist who will inform the Clinic Director. A reduction in fee to not less than \$5 per session of individual or group treatment may be approved.

CLIENT AGREEMENT:

Based on the above schedule, I understand that I will be expected to pay:

\$_____ for individual therapy at the time of service

\$_____ for group therapy prior to the first session, and \$_____ for each additional session

\$_____ for assessment services prior to the first assessment session

I acknowledge that these fees have been explained to me by the clinic associate, and that I agree to pay for the services as outlined in this document. If in the future my ability to pay for services changes, I will inform my therapist.

If I show up for services and am unable to pay for services based upon this agreement, I services will not be refused, but this will need to be discussed with my therapist, and directed to the Clinic Associate or Clinic Director for further review. In this circumstance, referral to other resources may be warranted, if minimal payments are not possible.

DATE: _____ CLIENT NAME: _____ CLIENT NUMBER: _____

 Signature of Client

 Signature of Clinic Associate

Date	Reason For Review	\$ Approved	PSC Director Signature	Signature of Client