



**FSU Psychology Clinic**  
**Regional Rehabilitation Center**  
**Room 214**  
**Tallahassee, FL 32306-1210**

## **Fee Policies and Income Information**

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Operating expenses of the Psychology Clinic are derived primarily from client fees rather than state or university funding. The standard fee for therapy is \$60 per hour. Fees for testing depend on the purpose of the evaluation and the specific tests administered. Questions about the range of our testing fees can be directed to the Assistant Director. The application fee required of all clients is \$25; \$35 for couples.

We recognize that our fees, though modest, may create a financial hardship for some individuals. We will make an attempt to be as fair and accommodating to your financial situation as is possible. If you are unable to pay the standard therapy fee or the testing fees quoted to you by staff, you can request approval for a sliding scale fee by completing the following section. Approval will be based on family financial resources and family size. Adjusted fees for therapy range from \$20 to \$60.

During your screening interview, the Assistant to the Director will inform you of your fee at that time and will be glad to discuss it with you. Individuals requesting therapy services will be scheduled for an initial 1½ hour intake session in which the therapist will obtain information about your background and your reasons for coming to the Clinic. The fee for the intake is based on your therapy session rate and you will be charged for 1½ sessions. Future sessions will generally last 50 minutes.

If you have insurance or HMO coverage that provides full or partial payment of mental health services, the clinic staff will assist you in filing for reimbursement. However, the clinic does not accept assignment of payment and all fees are due when services are rendered. There are some HMOs and other organizations that pre-approve payment for clinic services. If you are participating in an organization that pre-approves payment, please submit the proper forms to the office assistant before sessions begin. Please note that we do not accept Medicare or Medicaid.

Clients are expected to pay in full for each therapy session at the time of the appointment. Payment for psychological testing is due by the final session in which the client (or parents, in the case of a minor) receives feedback from the therapist. Half of the payment for the assessment is requested at the initial testing session.

Clients will be charged for missed appointments unless sessions are cancelled at least 24 hours in advance. Clients paying a flat fee for testing will be charged \$40 for each missed appointment and clients being seen for therapy will be charged the full session fee. Please note that insurance companies do not cover such charges; clients will be responsible for full payment of these fees.

**FSU Psychology Clinic  
Income Information**

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Payments are accepted in cash or by personal check, Visa, Mastercard, Discover, or American Express. Checks should be made payable to the FSU Psychology Clinic. If you would like a copy of this form for your records, please ask for one from the office staff.

1. Name of person/agency responsible for payment:

\_\_\_\_\_

Address of person/agency responsible for payment:

\_\_\_\_\_

Street	City	State	Zip
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Driver's License #: \_\_\_\_\_

SS#: \_\_\_\_\_

Height: \_\_\_\_\_ Race: \_\_\_\_\_

2. Person responsible for payment is currently:

- (1) working part time
- (2) working full time
- (3) unemployed

Occupation/Title: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

3. What is the annual family household income of the person responsible for payment?

\$ \_\_\_\_\_

4. How many people are supported by the income reported in #3?

- |                            |                                     |
|----------------------------|-------------------------------------|
| (1) one (myself)           | (4) four including myself           |
| (2) two including myself   | (5) five including myself           |
| (3) three including myself | (6) more than five including myself |

Please sign below and have your signature witnessed by a clinic staff member. If you plan to return the form by mail, please have your signature notarized.

\_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

I, \_\_\_\_\_, have read and understand the terms and (client name or parent/guardian name) conditions for payment set forth in the Psychology Clinic Fee Explanation/Schedule, and by my signature do hereby accept and agree to comply with said terms and conditions, and furthermore attest that the above provided information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Witness Signature

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**\*\* NOTARY USE ONLY \*\***

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

I HEREBY CERTIFY, that on this day personally appeared before me, an officer duly authorized to administer oaths and take acknowledgements, \_\_\_\_\_ to me well known to be the person who executed the foregoing acknowledgement.

WITNESS my hand and official seal in the State and County last aforesaid this the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

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**\*\*\* THIS SECTION TO BE COMPLETED BY OFFICE STAFF \*\*\***

Fee level: \_\_\_\_\_

MMPI-2: \$\_\_\_\_\_ CBC: \$\_\_\_\_\_

Therapy rate: \$\_\_\_\_\_ Sliding scale approved: Yes No

Assessment fee: \$\_\_\_\_\_ Reduced rate: \$\_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_