**THE GUIDANCE CENTER, INC.  
Fee Agreement Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Client’s Name: | |  | Payment Guarantor: |  |
| Initial all that apply | | | | |
|  | Initial assessment/evaluation fee: $200. Hourly fees: $250/individual, $100/group or as otherwise described. | | | |
|  | I understand that I am responsible for my co-pay, co-insurance, deductible, and any charges not covered by my insurance or other payer source. I agree to pay these charges at the time services are provided. | | | |
|  | I have signed appropriate billing releases. | | | |
|  | I request a sliding fee because I do not have insurance. I will pay this fee at the time services are provided. | | | |
|  | To support my request for sliding fee, I have provided the following documentation:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | Prior year’s tax return |  | Pay stub |  | Net worth statement | |  | Kansas Medical card |  | Bank statement showing direct deposit |  | Other | |  | W-2 |  |  |  |  | |  |  |  |  |  |  | | | | |
|  | The service I am requesting is not covered by insurance. I am responsible for the cost of that service. | | | |
|  | I understand my fee, as described below. | | | |
|  | I understand that failure to pay for service at the time of the appointment may prevent scheduling further appointments. | | | |
|  | **I certify that the above information is accurate. I agree to notify the Center of any changes in this information during the course of treatment.** | | | |

|  |  |  |
| --- | --- | --- |
| Client’s/Guarantor’s Signature, Date |  | Witness Signature, Date |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Fee Information** | | | | | | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | In-network copay: |  | |  | |  | Out of network copay: |  | | In-network deductible: |  | |  | |  | Out of network deductible: |  | | Copayment or Fee: | Assessment | |  | | Group |  |  | |  | Individual | |  | | Psychiatry |  |  | |  | Other service | |  | | | |  | |  |  | | Cost, description | |  |  |  | | **Income/Residency Information if Applicable** | | | | | | | | | Number of Income Recipients in Household | | |  | | Combined Annual Gross Income | |  | | Number of Persons in the Household | | |  | | Type of Kansas Residency Verification | |  | | Meets FPG? |  | No |  | Yes |  | % of FPG |  | |  |  |  |  |  |  |  |  | | | | | | | | | |
| **100% of Federal Poverty Guidelines (2021)** | | | | | | | | |
| Family Size | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Annual Income | $12,880 | $17,420 | $21,960 | $26,500 | $31,040 | $35,580 | $40,120 | $44,660 |
| Monthly Income | $1,073 | $1,452 | $1,830 | $2,208 | $2,587 | $2,965 | $3,343 | $3,722 |
| **200% of Federal Poverty Guidelines (2021)** | | | | | | | | |
| Family Size | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Annual Income | $25,761 | $34,841 | $43,921 | $53,001 | $62,081 | $71,161 | $80,241 | $89,321 |
| Monthly Income | $2,147 | $2,903 | $3,660 | $4,417 | $5,173 | $5,930 | $6,687 | $7,443 |