

California Lutheran University
Community Counseling Services
FEES

Welcome to the Community Counseling Services (CCS) at California Lutheran University. We are pleased that you have chosen to receive counseling services here. Please note that therapy provided at CCS is performed by Masters/Doctoral level Trainees and Registered Associate Marriage and Family Therapists. The Trainees and Registered Associates work under the direct supervision of licensed mental health professionals.

Please be aware that you will be expected to pay a fee for each counseling session that you or a family member receives (including the first session). It is your responsibility to pay before sessions in order to reduce your treatment from being disrupted. Your clinician will provide you with ways to pay for the session (e.g., online portal, mailing a check, etc.). The fee for your first session will be \$25.00. You must provide documentation of income **for all adults living in the home** (i.e., most recent pay stubs, W2, or federal income tax form) to your first session so that your therapist will be able to assess your ongoing session fee. Fees are based on your income (before taxes) and the number of individuals living in your household. Please note that group therapy sessions range from \$5-20. If you do not send in documentation, your fee will be set at \$75.

If there is a no-show or cancellation with less than 24-hour notice, your current session fee will be charged. A total of 3 no-shows/cancellations throughout treatment can lead to termination of services at CCS.

While CCS is sensitive to client needs, please note that having a balance on your account is not acceptable and should be discussed with your counselor. **Clients with unpaid balances for 2 sessions are ineligible to receive services until they pay their balance. In order to avoid service interruption, payment for such balances will need to be made 24 hours in advance of the next scheduled appointment. Otherwise, the appointment will be canceled.**

Please complete below:

1. Total Adults with Income (e.g., Job Salary, Social Security Benefits, Unemployment):

2. Do you receive any of the following?

____ Yes ____ No: Unemployment Benefits

____ Yes ____ No: Child Support

____ Yes ____ No: Disability Benefits

____ Yes ____ No: Social Security Benefits

3. Combined **MONTHLY** Household Income **Before** Taxes: \$_____

4. Number of Adults and Children in Household: _____

OR

1. If you live with roommates and do not combine income, please complete the following:
Monthly Income Before Taxes: \$_____

Clinician to Complete:

Client Fee: \$ _____

Comments:

Client/Parent/Guardian #1 Signature

Client/Parent/Guardian #1 Printed Name

Date

Client/Parent/Guardian #2 Signature

Client/Parent/Guardian #2 Printed Name

Date

Clinician Signature

Clinician Printed Name

Date