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). The fee for your first session will be $25.00. You must bring 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 family. Please note group therapy sessions range from $5-20. If you do not bring documentation, your fee will be set for $60.

If there is a no-show or cancellation with less than 24-hour notice, a fee of either $10 or current session fee (whichever is higher) will be charged. A total of 3 no-shows/cancellations over the course of treatment can lead to termination of services at CCS.

All fees will be reassessed a **minimum of three (3) times a year** on the 4th week of February, June, and October. You must bring new proof of income (i.e., most recent pay stubs, W2, or federal income tax form) for each re-assessment. 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. **Balances over $50 or lack of payment for 2 sessions make clients ineligible to receive services until they pay their balance.**

Please complete below:

Number of Adults with Income (e.g., Job Pay, Social Security Benefits, Unemployment): _____

Do you receive any of the following?

____ Yes ____ No : Unemployment Benefits
____ Yes ____ No : Child Support
____ Yes ____ No : Disability Benefits
____ Yes ____ No : Social Security Benefits

Combined **MONTHLY** Household Income **Before** Taxes: $_____

Number of Adults and Children in Household: _____

Total Number of Services Received at CCS (e.g., Individual + Couples = 2): _____

If you live with roommates and do not combine income, please complete the following:

Monthly Income Before Taxes: $_____

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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