University of North Texas
Speech and Hearing Center

Fee Adjustment Form

Client: ____________________

Address: ____________________

City: ____________ State: ________ Zip ____________

Parents or Legal Guardian(s) ____________________
(If client is under age 18)

Fee Adjustment Information: (All fields are required)

Gross household income $ ____________ Yearly or Monthly
(Circle one)

Number of members in household (including yourself) ____________

Yearly out-of-pocket medical expenses: $ ____________________

____
(Signature of client or parent) (Date)

____
(Signature) (Date)

Evaluation normal fee: $ ______ Therapy normal fee: $ ______

Adjustment: $ ______ Adjustment: $ ______

Adjusted (new) fee: $ ______ Adjusted (new) fee: $ ______

Clinic use only:

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A new Fee Adjustment Form is due at the start of each school year. Sliding-scale fees will be re-evaluated based on continued need and the Center's current pricing structure.

Documentation of household income is required.