2851 S. Parker Rd.
Suite 656
Aurora, CO 80014

4101 E. Louisiana Ave.
Suite 447
Denver, CO 80246

** Tel: (720) 347-8559 ** www.CenterForValuedLiving.com ** Fax: (720) 207-6885 **

SLIDING SCALE FEE AGREEMENT

I, _____, certify that I do not have health insurance (or certify that I will not / cannot utilize any health insurance for services rendered by the Center of Valued Living, PLLC and/or due to my current financial situation, I cannot afford the full fee rate of $120/session. I therefore, request that my fee be adjusted. I have estimated my expenses using the Sliding Scale Fee Guidelines and Monthly Expense Worksheet for this purpose (see page 2).

My current monthly income is currently insufficient to cover my monthly expenses and therapy at the rate of $120/session. This is also true of my total household income, if living with a partner. Therefore, I understand that the fee for services with Center for Valued Living, PLLC will be _____/session and is payable at the time of each session (unless other arrangements are made in advance).

I further understand that I will not be charged for any appointments that are cancelled at least 48 hours in advance. I understand that appointments not cancelled at least 48 hours in advance are subject to a "Late Cancellation" or "No Show" charge of my contracted rate above. I understand that I am solely responsible for all these charges as they apply, as well as, the costs associated with collecting these charges.

I agree to notify the Center for Valued Living, PLLC of any substantive changes in my financial situation (e.g., 10% increase or decrease in income) within 30 days of the change, and understand the fee may change according to my updated financial situation. I further acknowledge that my therapist will periodically verbally review my financial status with me, approximately every 8-10 consecutive weeks, in order to reassess eligibility. A continuance of Sliding Scale benefits is not guaranteed and is subject to modification and/or elimination at the sole discretion of the Center for Valued Living, PLLC.

_____ _____
Client Print Name Date

_____
Client Signature

Lisa Michelle Griffiths, PsyD_____ _____
Therapist Print Name Date

_____
Therapist Signature

General Guidelines for Sliding Scale Payments:

Please *circle* the total annual gross income earned by all employed members of your household. Children and other dependents would be included in the total number of household members.

Single Person Household Income	Two Person Household Income	Three People Household Income	Four People Household Income	Five People Household Income	Six People Household Income
$15,300.00 **$60**	$20,500.00 **$60**	$25,700.00 **$60**	$31,000.00 **$60**	$36,200.00 **$60**	$41,400.00 **$60**
$18,480.00 **$60**	$23,250.00 **$60**	$28,015.00 **$60**	$32,875.00 **$60**	$37,640.00 **$60**	$42,410.00 **$60**
$21,660.00 **$65**	$26,000.00 **$60**	$30,330.00 **$60**	$34,750.00 **$65**	$39,080.00 **$60**	$43,420.00 **$60**
$24,840.00 **$65**	$28,750.00 **$65**	$32,645.00 **$65**	$36,625.00 **$65**	$40,520.00 **$65**	$44,430.00 **$60**
$25,950.00 **$70**	$31,500.00 **$65**	$34,960.00 **$65**	$38,500.00 **$70**	$41,960.00 **$65**	$45,440.00 **$65**
$29,130.00 **$70**	$34,250.00 **$70**	$37,275.00 **$70**	$40,375.00 **$70**	$43,400.00 **$70**	$46,450.00 **$65**
$32,310.00 **$75**	$37,000.00 **$75**	$39,590.00 **$75**	$42,250.00 **$75**	$44,840.00 **$70**	$47,460.00 **$65**
$37,755.00 **$80**	$39,750.00 **$80**	$41,905.00 **$80**	$44,125.00 **$75**	$46,280.00 **$75**	$48,470.00 **$70**
$40,935.00 **$90**	$42,500.00 **$85**	$44,220.00 **$85**	$46,000.00 **$80**	$47,720.00 **$80**	$49,480.00 **$70**
$44,115.00 **$100**	$45,250.00 **$90**	$46,535.00 **$90**	$47,875.00 **$85**	$49,160.00 **$80**	$50,490.00 **$75**
$47,295.00 **$110**	$48,000.00 **$100**	$48,850.00 **$95**	$49,750.00 **$90**	$50,600.00 **$85**	$51,500.00 **$80**
$50,475.00 **$115**	$50,750.00 **$110**	$51,165.00 **$105**	$51,625.00 **$95**	$52,040.00 **$90**	$52,510.00 **$85**
$53,500.00 **$120**	$53,500.00 **$110**	$53,500.00 **$100**	$53,500.00 **$100**	$53,500.00 **$95**	$53,500.00 **$90**

Monthly expense worksheet:

	Column A		**Column B**		**Column C**
Rent or mortgage		Entertainment /dining out		Car maintenance	
Utilities		Food		Travel	
Internet		Gas (car)		Clothing/Shoes	
Car payment		Gym		Credit Card Debt	
Car Insurance		Pets		Student Loans	
Other transportation		Personal Care		Other loans	
Health Insurance		Prescription Drugs		Other	
Other Insurance		Other Healthcare		Other	
Home Phone		Tuition		Other	
Cell Phone		Childcare		Other	
TOTALS:		**TOTALS:**		**TOTALS:**	

Add the totals for columns A, B, and C: _____

Multiply this number by 12 for your annual expenses: _____

If the number exceeds your annual income, you may be eligible for a Sliding Scale Fee. Please note the posted fees are guidelines and may be adjusted based on your income, expenses, and ability to pay.