

**University of North Texas  
Speech and Hearing Center**

**Fee Adjustment Form**

Client: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Parents or Legal Guardian(s) \_\_\_\_\_

**Fee Adjustment Information: (All fields are required)**

Adjusted Gross household income Monthly \$ \_\_\_\_\_ Yearly \$ \_\_\_\_\_

Subtract Yearly out-of-pocket medical expenses: \$ \_\_\_\_\_

Yearly Income for sliding scale (Adjusted gross minus medical expenses) \$ \_\_\_\_\_

Number of members in household (including yourself) \_\_\_\_\_

\_\_\_\_\_  
Signature of Client or Parent

\_\_\_\_\_  
Date

**Clinic Use Only (upon verification of above information):**

	1 hour	30 min
Evaluation normal fee: \$ _____	Therapy normal fee: \$ _____	\$ _____

Adjustment: \$ _____	Adjustment \$ _____	\$ _____
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Adjusted (new) fee: \$ _____	Adjusted (new) fee: \$ _____	\$ _____
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\_\_\_\_\_  
UNT Speech & Hearing Center Representative

\_\_\_\_\_  
Date

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. Please provide either copies of your prior year's tax return or paycheck stubs for prior 3 months for your household. If unavailable, please discuss with Center's Billing Coordinator.**