LIPSCOMB UNIVERSITY

Family Therapy Center

Proof of Income Verification

Clients are eligible for the sliding fee scale by filling out this form and providing proof of income (e.g., check stub, Tax Form 1040). Clients unable to provide proof of income are charged the maximum fee per session (i.e., $90.00 per clinical hour). Lipscomb University students are exempt from all fees.

Client Name: _____

Address: _____

_____

Birthdate: _____

Gross Annual Income (i.e., prior to taxes): _____

Number of individuals provided for by the gross annual income listed above: _____

By signing below, I certify that the information I provided on and in connection with this form is true, accurate, and complete. I understand that any changes in my income will result in a reassessment of my sliding scale fee and that it is my responsibility to notify my therapist intern or other Lipscomb Family Therapy Center faculty or staff if there are any changes to my gross annual income. I understand that the Lipscomb Family Therapy Center relies on client fees in order to offer affordable services to clients in need. Additionally, I understand that I may request an alternate payment schedule by submitting a Sliding Fee Scale Adjustment Affidavit to my therapist.

_____ _____

Client Signature Date

The bottom portion of this form is to be completed by Lipscomb Family Therapy Center staff.

Type of income verification used (attach a photocopy of the client's proof of income):

- ☐ *Lipscomb University Student (exempt)*
- ☐ *Tax Form 1040*
- ☐ *Check Stub*
- ☐ *Other (must be approved by the clinic director)*

If applicable, explain why the Tax Form 1040 or Check Stub was not used for verification:

_____

_____

Established fee per clinical hour: $ _____

_____ _____

Therapist Signature Date

_____ _____

Clinic Director Signature (if necessary for approval) Date