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BILLING INFORMATION AND FEE SCHEDULE

The purpose of providing this written information is to clarify the financial aspects of my work on behalf of your child.

Payment is accepted in the form of cash, checks, or credit cards before the end of each therapy session.

Prior to our first appointment please contact your insurance company to determine your benefits for outpatient mental health treatment, including relevant deductibles and requirements for pre-authorization if needed. At your prompting, I will fill out treatment plans or call case managers to help you access your benefits.

Fee Schedule:

Initial appointment rate is $200. This session lasts 60-90 minutes. (CPT code 90791)

F*ollow-up therapy appointments*: Therapy appointments subsequent to the initial appointment are billed at a rate of $160 for a 45 minute session. (CPT code 90834) and at a rate of $180 for a 60 minute session (CPT code 90837)

Testing: Computer assisted testing will be billed at a rate of $100 per test.

Legal Work: Any legal case involvement (preparation, letter or reports to the court, phone calls, depositions or court testimony) whether under subpoena or not is billed at $400 per hour. A retainer of $2400 is required.

Out of office professional services: Out of office services such as home visits or school visits are billed at the rate of $300 per visit.

Telephone consultations: Telephone consultations are often necessary from time to time during treatment. Calls in excess of 15 minutes may be billed at the follow-up therapy rate and will be prorated based on the length of the telephone consultation. There is no charge for calls about scheduling appointments or calls regarding other administrative issues.

Missed appointment fees: A 24-hour cancellation notice is required. There is not a charge for appointments that are canceled with 24-hour notice. If you cancel with less than 24-hours notice you will be billed for the appointment unless someone else is able to use your appointment time. You may leave a message on my confidential voice mail with appointment concerns and rescheduling needs.

Your signature below indicates your understanding of these policies and your acceptance of the financial responsibility described within this document.

Name of patient:_____
Date:_____
Printed name of person signing this document _____
Signature of person responsible for payment_____