DISCOVERY COUNSELING & CONSULTING

Fee Schedule

Unless noted otherwise, fees for services are as follows:

SELF PAY RATES (IF NOT COVERED BY INSURANCE):	
Initial Intake Therapy Appointment	$185.00
Individual Therapy Appointment (90837, 90847, 90846)	$165.00
Individual Therapy Appointment (90834)	$110.00
Individual Therapy Appointment (90832)	$85.00
Group Therapy Appointment	$60.00
Initial Psychiatric Evaluation (up to 60 minutes)	$225.00
Medication Management Follow-up Appointment (up to 45 min)	$104.00-$206.00
Medication Management Therapy Add-On	$80.00
FEES NOT COVERED BY INSURANCE:	
Dialectical Behavior Therapy (DBT) Program Fee	$250.00
Medication refill requests between appointments	$25.00
Therapy Appointment Extension (30 min intervals)	$85.00
Psychological or Educational Testing (includes Administration, scoring, report writing)	$200.00/hr
School Meetings (includes travel time)	$165.00/hr
Deposition/ Court Appearance (LCP, LCSW, LPC, LMFT includes travel time)	$250.00/hr
Deposition/ Court Appearance (PMHNP includes travel time)	$500.00/hr
Letters and form completion	$100.00/hr
No Show or Late Cancellation Fee	$85.00
Group No Show or Late Cancellation Fee	$35.00
Telephone calls (more than fifteen minutes and non-emergency)	$165.00/hr
Copy of Medical Record Processing Fee (plus $0.50 per page up to 50 pages and $0.25 per page thereafter)	$10.00

By signing below, I acknowledge that I have read and understand this financial agreement.

I hereby request that payment of authorized insurance benefits, including Medicare, be made on my/my child's behalf to DCC for any services provided to me/my child by DCC. I authorize release of any medical or other information by DCC necessary to process my/my child's claims. I understand that I am financially responsible for any charges not covered by my/my child's insurance. I understand that as a part of utilizing my health insurance benefits, there may be times where my health insurance company requests copies of my medical records for the purposes of standard audits and reviews. I understand that DCC is required to submit this documentation in order to remain in compliance with health insurance contracts and I will not necessarily be notified when this information is disclosed.

Client Name:____

Responsible Party Name: ____

Relationship to Client: ____

Responsible Party Signature: ____ Date: __________