**Fee Agreement for Kelly A Brey PhD PC**

|  |  |  |  |
| --- | --- | --- | --- |
| CPT | Description of Procedure - Psychologist | Minutes | Fee |
| 90791.95 | Initial Assessment | 60 | $325 |
| 90832.95 | Individual psychotherapy  | <=37 | $200 |
| 90834.95 | Individual psychotherapy  | 38-52 | $250 |
| 90837.95 | Individual psychotherapy  | 53-60 | $275 |
| 90837.95 | Individual psychotherapy (used in rare circumstances only) | 61-90 | $300 |
| 90846.95  | Family counseling w/o patient  | <=37 | $200 |
| 90846.95 | Family counseling w/o patient  | 38-52 | $250 |
| 90846.95 | Family counseling w/o patient | 53-60 | $275 |
| 90847.95 | Family counseling  | <=37 | $200 |
| 90847.95 | Family counseling  | 38-52 | $250 |
| 90847.95 | Family counseling | 53-60 | $275 |
| 90847.95 | Family counseling (rare circumstances only) | 61-90 | $300 |
| Phone Call | Therapist phone call over 5 minutes (charges accrue in 15 min intervals) | 15 | $50 |
| 90882 | School/Agency/Community Consultation (charges accrue in 15 min intervals) | 15 | $50 |
| 96101 | Psychological testing and interpretation | 60 | $215 |
| Legal | All items related to legal concerns (testimony, deposition, preparation, documentation, travel, etc). Charges accrue in 60 min intervals.  | 60 | $300 |
| NSF | Check returned NSF | n/a | $30 |

I/We, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge reviewing the above information, and have had the opportunity to ask whatever questions necessary for clarification. I understand that I will be charged for services provided by Kelly A. Brey PhD PC according to the fees listed above. I understand that I am responsible for all fees, regardless of whether my insurance pays for services, and I agree to make payments at the time service is provided.

Patients are allowed one late cancel (within 24 hours of scheduled appointment time) or no-show with no cost. Subsequent late cancels/no-shows will be charged the full fee of the scheduled appointment. If a patient has 3 late cancels/no-shows in one-year, therapeutic services with Dr. Brey will be terminated, and outside therapy referrals will be provided.

**I understand that any missed appointments are charged at the full fee of the appointment scheduled and that I am responsible for that fee as insurance will not reimburse for missed appointments or late cancellations.**

**I understand statements for out-of-network insurance submission are produced electronically once a month via an online portal account.**

I understand that there will be a monthly service charge of 0.75% of any unpaid fees (9%/year), and that balances not paid in a timely manner may be turned over to an independent agency for collection.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date Patient Signature Date