Melanie J. Bliss, Ph.D.
Licensed Psychologist

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Decatur, GA 30030

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FEE SCHEDULE AND BILLING INFORMATION FOR MELANIE BLISS, PH.D., LLC

Service:	**Hourly Fees**:
45-50 minute psychotherapy session or consultation appointment (individual, family, or couple)…………………………………………………………	$170.00
Psychotherapy first session / intake……………………………………………...............	$185.00
No-show or late cancellation (within 24 hours)……………………………………..	$170.00
Psychological Evaluations and report writing ……………………………………	$170.00/hour
Legal proceedings including any of the following: forensic interviews; interviews; evaluations; report writing; document review; court preparation; meetings; transportation for all testimony, depositions, hearings, meetings, etc. …………………………………………………………………	$250.00/hour
Legal proceedings including full amount of time served for court testimony, depositions, and hearings, including wait time. All are regardless of location and regardless of party who summons my participation…………………………………………………………...………………………	$300.00/hour
Other professional clinical services you request of me, including non-court report or letter writing on clients' behalf, phone conversations lasting longer than 5 minutes, preparation of records or treatment summaries, and copying of files. Includes transportation time if applicable……………..	$170.00/hour or 2.83/minute
Returned checks………………………………………………………………………………..	$15.00 plus bank charges

<u>Additional Information</u>:

1. I reserve the right to raise my fees due to changes in the market. I will always discuss a potential fee increase with you before raising your fee. Generally I raise my fee $5.00 each spring.
2. The fee schedule may be adjusted for some clients experiencing particular financial hardship or other extenuating circumstances. Additional documentation may be required in order to receive a reduced rate. Discounts are not necessarily granted.
3. You will be expected to pay for each session at the time it is held unless we agree otherwise or you have insurance coverage for the entire session. Payment schedules for other professional services will be agreed to at the time these services are requested. I prefer payments through cash or check but also accept MasterCard or Visa.

4. I am “out of network” for insurance companies. If you wish to use insurance and I am “out of network” for your insurance company, you must pay my fee in full. I will give you an invoice to submit to your insurance company and they will reimburse you based on your out of network benefits.
5. *Once an appointment is scheduled, you will be expected to pay for the full session unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.*
6. If your account has not been paid for more than 60 days and a payment plan has not been agreed on, I will submit the charge to your credit card company using the credit card information you provide on this form.
7. **If you are an attorney retaining my services for legal purposes**, I require a retainer of $2,000.00 up front (negotiable based on circumstances) and regular payments after the completion of work. I require payment for all services rendered prior to releasing a written report and prior to providing testimony or a deposition. The minimum number of hours for a deposition in my office is two, and the minimum number of hours for a deposition or testimony for which I must travel is four hours.

I agree to the billing practices noted above. I also understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event that I default on payment of my bill, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that this may include information from my chart. I further agree that a photocopy of this agreement shall be as valid as the original.

Client signature: ___________________________________ Date:_____________________

My policy is to maintain a credit care on file. This allows me to settle your account quickly and easily should you find yourself without your usual form of payment so that you do not end up with an outstanding balance on your account. By providing your credit card information here you are giving me permission to run the card you choose automatically if services have been rendered and not paid for or if you do not provide at least 24 hours notice of a cancellation.

Responsible party signature (if different from patient): ___________________________________

Credit Card number: ________________________________ MasterCard or Visa

Expiration date: _______ 3 digit security code: _________ Name on Card: _________________

Signature matching name on card: ____