

**Fee Disclosure Statement**  
 effective 12/31/2017

The following is a list of services that may be provided to you by ERC. ERC reserves the right to make changes to the Fee Schedule below. In the case of a change, you will be provided, at minimum, 30-day notice before the initiation of the new schedule. ERC offers a sliding scale fee. Speak to your counselor if you are interested in applying. If you have questions or concerns, please discuss with your counselor.

Description	CPT Code	Time	Fee	Self-Pay Fee*
Diagnostic Evaluation	90791	45-60 minutes	\$175	\$150
Psychotherapy, 30 minutes with patient and/or family member	90832	16-37 minutes	\$80	\$70
Psychotherapy, 45 minutes with patient and/or family member	90834	38-52 minutes	\$120	\$95
Psychotherapy, 60 minutes with patient and/or family member	90837	53-60 minutes	\$150	\$120
Family psychotherapy without the patient present	90846	60-90 minutes	\$150	\$120
Family psychotherapy, conjoint psychotherapy with the patient present	90847	60-90 minutes	\$150	\$120
Group psychotherapy	90853	30-60 minutes	\$65	\$40
Psychotherapy for crisis, first 60 minutes	90839	30-74 minutes	\$150	\$120
Add-on for each additional 30 minutes for psychotherapy for crisis	90840	Every 30 minutes after the first 74 minutes	\$80	\$70
No-Show Fee	Not billable	N/A	\$50	\$50
Returned Check Fee	Not billable	N/A	\$35	\$35
Involvement in legal proceedings	Not billable	1-60 minutes	\$350/hour, rounded <b>up</b> to the nearest hour	\$350/hour, rounded <b>up</b> to the nearest hour
Copy of Records	Not billable	N/A	\$0.30/page	\$0.30/page
<b>Other professional services:</b> including but not limited to telephone calls lasting more than 15 minutes, report writing, consulting with other professionals at the request of the client, etc.	Not billable	1-60 minutes	\$100/hour billed in 15-minute increments	\$80/hour billed in 15-minute increments

\*Payment must be collected at the time of the visit to qualify for this rate.

By signing below, you agree you have been provided a copy of this statement and understand the fees associated with services provided at ERC.

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 Print Name

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 Signature

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 Date

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 Medicaid # (if applicable)