

Fee Disclosure Statement
 effective 10/15/2018

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, a 30-day notice before the initiation of the new schedule. ERC offers a limited number of reduced fee appointments. 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	\$70	\$70
Returned Check Fee	Not billable	N/A	\$35	\$35
Involvement in legal proceedings: Record Review Travel & Waiting Time in Court Court Testimony	Not billable	1-60 minutes	\$150/hour** \$150/hour** \$350/hour***	\$150/hour** \$150/hour** \$350/hour***
Copy of Records	Not billable	N/A	\$0.30/page	\$0.30/page
Other professional services: 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	\$150/hour**	\$150/hour**

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

Billed in 15-minute increments. *Billed in 1-hour increments, rounded *up* to the nearest hour.

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

 Print Name

 Signature

 Date

 Medicaid # (if applicable)