Powers Ferry Psychological Associates 3860 Windermere Parkway, Bldg. 203 Cumming, GA 30041 770-953-4744 Fax: 770-953-4640

## Susan Berel, PH.D., - Fee Schedule & Assignment of Benefits

| •                               | Annual Administrative Fee   | \$10  | yearly                                |
|---------------------------------|---|-------|---------------------------------------|
| •                               | Initial Consultation Sessions<br>90791 - at least 53 min and not more than 90 min   | \$170 | per hour                              |
| •                               | Individual Therapy 90837 – ≥ 53 minutes   | \$160 | per hour                              |
| •                               | Family / Couples Therapy<br>90846 without the client $\geq$ 53 minutes<br>90847 with the client $\geq$ 53 minutes   | \$160 | per hour                              |
| •                               | Other Services - to include: report / letter writing, telephone calls longer than 5 min mailing, etc. prorated based on the amount of time spent at   |       | per hour n 5 minutes, record copying, |
| •                               | Legal Work  | \$350 | per hour                              |
| •                               | Missed/Late Cancellation of an appointment within less than <u>24</u> hours notice  | \$100 |                                       |
| 1.                              | I understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.  |       |                                       |
| 2.                              | I hereby authorize and request the insurer(s) that I or my child am covered under to pay directly to <u>Susan Berel, Ph.D.</u> any benefits due under the terms of this policy for services rendered to the following address: <u>1827 Powers Ferry Rd. Bldg 22, Marietta, GA. 30339.</u> |       |                                       |
| 3.                              | I understand and agree to pay the above fee schedule if I fail to cancel my appointment within 24 hours or miss the appointment except in case of emergency.  |       |                                       |
| Client'                         | 's Name (please print)  |       |                                       |
| Signature of client or guardian |   | Date  |                                       |
| Signature of psychologist       |   | Date  |                                       |