Powers Ferry Psychological Associates, L.L.C.

1827 Powers Ferry Rd., Bldg. 22, Atlanta, Ga. 30339
770-953-4744 Fax: 770-953-4640

Provider Name Addam Wawrzonek, PH.D., BCBA, - Fee Schedule & Assignment of Benefits

- Annual Administrative Fee — $12 yearly
- Initial Consultation Sessions — $300 per hour
  90791 - at least 53 min and not more than 90 min
- Individual Therapy — $190 per hour
  90837 – ≥ 53 minutes
- Family Therapy — $190 per hour
  90846 without the client - ≥ 53 minutes
  90847 with the client – ≥ 53 minutes
- Educational Consultation with Schools — $190 per hour
  - Phone consultation and participation in school meetings (includes travel time)

- Psychological Testing Material Fee (variable one time) — $150-250

- Psychological Testing — $200 per hour
  96130 – 96133, 96136 – 96139
  Includes administration, scoring, interpretation, report writing

- Other Services - to include: — $200 per hour
  report / letter writing, telephone calls longer than 5 minutes, e-mails longer than 5 minutes, record copying, mailing, etc. prorated based on the amount of time spent at the hourly rate.

- Legal Work **(DEPOSIT REQUIRED)** — $375 per hour
  - Retainer fee of 5 hours is required. Includes phone consultations, preparation for court-related work, travel time, time in court, etc.

- Missed Appointments/Late Cancellations for Testing — $400 & up
  - Includes cancellations with less than 5-day notice on business days
- Missed Appointments/Late Cancellations (non-testing) — $190 & up
  - Includes cancellations with less than 24-hour notice on business days

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 are covered under to pay directly to Addam Wawrzonek, Ph.D, BCBA. any benefits due under the terms of this policy for services rendered to the following address: 1827 Powers Ferry Rd. Bldg 22, Marietta, Ga. 30339.
3. I understand and agree to pay the above fee schedule if I fail to cancel my appointment within the allotted time listed above or miss the appointment except in case of emergency.

_____ _____
signature of patient or guardian date

_____ _____
signature of psychologist date