DAVID L. TERLETZKY, Psy.D.
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Child, Adolescent & Adult Therapist
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...a parenting system for Parent and Child
Specializing with Children, their Families, and Couples

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Schedule of Fees

The following represents my fees for services. Currently, I am considered "**out-of-network**" with all insurance providers, and therefore your insurance provider may or may not consider my fees to be "usual and customary". Some of my fees may be outside your insurance plan's allowed amounts, plus varying individual insurance plans may not cover some of the listed services. **Please note:** if you are using your insurance benefits to help pay for services, it is your responsibility to pay any amounts or services not covered, or denied, by your insurance provider, unless I have an agreement with that company to provide services within a given financial range. I have provided a list of questions on my website for you to use in contacting your insurance provider, to better understand your actual benefits (www.DrDaveT.com on the Rates & Insurance page). Any questions you have regarding this schedule of fees can be directed to me at any time.

Service	Fee	CPT code
Psychiatric Interview	$240	90791
Psychotherapy ~ 45 min	$180	90834
Psychotherapy ~ 55 min	$220	90837
Interactive Add-on code	$25	90785
Family Psychotherapy without client	$200	90846
Family Psychotherapy, conjoint	$200	90847
Marital/Couples Therapy	$180	(No code)
Group Psychotherapy	$60	90853
Interpretation or Explanation of results/Advising	$180	90887
Preparation of report of client's status or progress for other professionals, 1 hr. minimum	$170	90889
Psychological Testing, per half-hour	$90	96136/96137
Letters & extended phone consultations are billed in 15 minute increments based on an hourly rate of …….	$200	
Court Testimony, which includes all meetings, preparations, and court appearances (including travel, waiting and scheduled and/or actual testimony time), are paid at the hourly rate of…	$275	

Your signature below indicates that you have read and understand this Schedule of Fees, and that you accept it as a condition of therapy services.

_____ _____

Signature of Person Responsible ***Date signed***