Powers Ferry Psychological Associates, LLC

1827 Powers Ferry Rd., Bldg. 22, Atlanta, GA 30339
www.atlantapsychologist.com * 770.953.4744, x25 * ksmiley@pfpaga.com

Fee Schedule & Assignment of Benefits — Kimberly Smiley, Psy.D.

Annual Administrative Fee	**$10**
Initial Assessment Session - *CPT Code: 90791 - at least 53 min and not more than 90 min*	**$200**
Individual Therapy Session - *CPT Code: 90837 - at least 53 minutes*	**$180**
Family/Couples Therapy Session - *CPT Code: 90847 - with the client - at least 53 minutes* - *CPT Code: 90846 - without the client - at least 53 minutes*	**$180**
1st Missed Appointment/Late Cancellation - *With less than 24 hours' notice*	**$50**
Additional Missed Appointments/Late Cancellations - *With less than 24 hours' notice*	**$180**
Other Services Including: - *Report/letter writing, telephone calls longer than 5 minutes, e-mails longer than 5 minutes, record copying, mailing, form completion, etc.* - *Fees are prorated based on the amount of time spent at the hourly rate.*	**$180/hour**
Legal/Court Work - *Includes but is not limited to travel time, phone consultations, court time, depositions, etc.*	**$500/hour**

Payment Agreement

1. I have read, understand and agree to the fee schedule provided above.
2. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.
3. If I elect to use insurance or government benefits to cover services, I hereby authorize and request the insurer(s) or government agency (agencies) to pay directly to Kimberly Smiley, Psy.D., LLC, any benefits due under the terms of my policy (policies) for services rendered by Kimberly Smiley, Psy.D., Licensed Psychologist, directly to the following address: 1827 Powers Ferry Road, Building 22, Atlanta, GA 30339.
4. I understand that it is my responsibility to pay for appointments that I fail to cancel within 24 hours, or for appointments that I miss, except for any that I miss because of an emergency. I agree to pay for any late cancelled or missed appointments according to the fee schedule provided above. I understand that my insurance company will not pay for these fees. I understand that this fee may increase after my first missed appointment/late cancellation.
5. I understand that there may be a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

YOUR SIGNATURE BELOW INDICATES THAT YOU UNDERSTAND AND AGREE TO THE FEE SCHEDULE AND PAYMENT TERMS OUTLINED ABOVE.

_____
Patient Name (please print)

_____ _____
Signature of Patient or Guardian **Date**

_____ _____
Signature of Psychologist **Date**