# OFFICE PRACTICES

Troy E. Johnson, PsyD, LLC
11978 Fishers Crossing Drive Fishers, IN 46038

PLEASE REVIEW THE FOLLOWING POLICIES AND INITIAL EACH.

**PROFESSIONAL FEES**: The following are the most commonly billed fees that I typically submit to your insurance company, though your personal responsibility will vary based upon my contract with your insurance company. If you are not using insurance or if your insurance denies the submitted service, you will be responsible for the following fees in full.

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| • Diagnostic interview examination, CPT code 90791 | $175.00 |
| • Psychotherapy 45 (38 – 52 min), CPT code 90834 | $100.00 |
| • Psychotherapy 30 (16 – 37 min), CPT code 90837 | $75.00 |
| • Family Psychotherapy, CPT code 90846, 90847, 90849 | $150.00 |
| • Psychological Test Administration/Scoring CPT code 96136/96137 | $75.00 per unit |
| • Psychological Test Evaluation CPT code 96130/96131 | $150.00 per unit |

In addition to therapy appointments, I charge $100.00 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. *My scope of practice does not include forensic psychology and I do not solicit business of a legal nature*. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding. *Initial here:* _____

**BILLING AND PAYMENTS:** As a courtesy, I will submit a bill to your insurance company on your behalf; however, you (not your insurance company) are responsible for full payment of my fees. You are responsible for co-payments / co- insurance amounts and deductibles as set forth by your benefit plan. You will be expected to pay for each session at the time it is held***. Future appointments will not be scheduled until copayments and / or deductible expenses have been paid.*** *Initial here:* _____

**CANCELLATION / MISSED APPOINTMENT POLICY:** Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you will be billed a missed appointment fee of $50. Your insurance company cannot be billed for fees associated with missed or canceled appointments. Repeated missed/canceled appointments may result in termination of services or referral to another practitioner. *Initial here:* _____

**CONTACTING ME:** Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call within 48 hours, with the exception of weekends and holidays. In the event of a mental health emergency, you may contact Community Health Network's 24 hour crisis line at (317) 621-5700, St. Vincent's Stress Center at (317) 338-4800 or your local police department. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. *Initial here:* _____

**Signing below acknowledges that you have read and agree to these policies.**

Patient Name / Date of Birth:_____

Signature of Patient or Guardian: _____ Date: _____