

**Fee Schedule**

**Psychotherapy**

Initial 60-minute consultation	\$200
50-60 minute session	\$175
40-45 minute session	\$150
30-minute session	\$100

\*\* If I have an agreement with your insurance company to accept a different fee, I will honor that agreement.

**Psychological Testing**

Per each hour of time (includes administering, scoring, and report writing)	\$175
Deposit due on day of testing (with remaining balance due at feedback session)	\$300

\*\* If I have an agreement with your insurance company to accept a different fee, I will honor that fee. Many insurance companies will not reimburse for testing and/or they may not authorize a sufficient number of hours to complete the testing. In that case, you would be responsible for payment of the entire fee.

**Psychological Evaluation for Immigration Proceedings**

\$600 (\$300 deposit due on date of session remaining balance due with report)

**Other Professional Services**

Per hour rate	\$175
---------------	-------

\*\* These services include report writing, telephone conversations exceeding 15 minutes, consulting with other professionals with your permission, school observations/consultations with your permission, preparation of records or treatment summaries, and time spent performing any other specific service you may request.

---

**FEE AGREEMENT**

Unless other arrangements are made, fees are as listed and are due at each session or at the time service is rendered. I am unable to submit insurance claims but will provide you with the necessary documentation and guidance to file claims with your insurance provider. **The full session fee will be charged for missed appointments cancelled less than 24 hours in advance.** Insurance companies will not reimburse for missed appointments.

---

I have read, understand, and agree to the above. I agree to accept the services of Alyssa M. Revuelta, Ph.D. and to accept the fees for those services as lawful debt. I agree to pay said fees as outlined above. This includes an agreement to pay costs of collections, attorney fees, and court costs, if necessary. I waive now and forever the right to claim exception under the Constitution and laws of the State of South Carolina or any other state. I also understand that failure to pay these fees may result in release of my name, known phone numbers, and addresses, other information during the collection process.

**Permission for Treatment or Services**

Permission is hereby given to Alyssa M. Revuelta, Ph.D. to render treatment and/or service to

\_\_\_\_\_ whose relationship to me is \_\_\_ Self \_\_\_ Child \_\_\_ Other (Specify: \_\_\_\_\_)

Your Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_