Behavioral Healthcare Corporation
Mental health for all we serve.

Outpatient Psychiatric Clinic Fee Schedule

Thank you for choosing Behavioral Healthcare Corporation (BHC). We are committed to providing you with the best quality services at the best possible rates. We appreciate the personal and financial investment required to engage in our services. Fees for services are rounded to the nearest 15 minute increment for billing purposes. Please note that our rates are presented here as the same for all payers. In the event that you have insurance that we accept, those fees may be different, and in many instances are paid in full. In the event that you do not have insurance that we accept, we will gladly contract with you individually at the same rate that we may accept as payment in full from other insurances. The following is a statement of our financial policy and fees which we require that you read and accept prior to the start of services.

EVALUATION / MEDICATION MANAGEMENT CODES **

Psychiatric Evaluation/Physician	285.00
Pharmacologic Management by Physician	95.00 **
Initial Evaluation/Psychotherapist	200.00
Initial Evaluation/CNS/Psychologist	200.00
Medication Training/Support, Med Admin provided by nurse per 15min unit	35.00
Psychological Testing, Complex Level - 60min	200.00 **

** *Minimum fee. Extended time and complexity will constitute additional fee*s.

PSYCHOTHERAPY CODES *

	Psychotherapist	**CNS/Psychologist**	**Physician**
Individual/Family Psychotherapy, 20 – 30 min	70.00	105.00	
Individual/Family Psychotherapy, 45 – 50 min	105.00	160.00	
Individual/Family Psychotherapy, 75 – 80 min	175.00	265.00	
Indiv. Psychotherapy w/Med Eval, 20 – 30 min			143.00
Indiv. Psychotherapy w/Med Eval, 45 – 50 min			214.00
Indiv. Psychotherapy w/Med Eval, 75 – 80 min			356.00
Group Psychotherapy, 75 – 80 min	60.00		

* *Interpreter services may constitute additional fees.*

Financial Statement

In consideration for the services provided by BHC, I/we accept financial responsibility to pay BHC. Payment is expected at the time of service unless I have made other arrangements for direct payment with or through my insurance company, Medicaid, or Medicare (Third Party Payers).

Third Party Payers require that BHC provide them with health care information and/or records in order to verify that I am eligible to receive services or to pay for services provided by BHC. I consent to the release of my health care information or records to my third party payer. The health care information or records released will include that which is necessary to establish my eligibility for services and to establish a claim for reimbursement for services provided to me consistent with the policy, procedures and requirement of my Third Party Payer.

ASSIGNMENT OF INSURANCE BENEFITS- I hereby authorize payment directly to BHC and any agency contracted by BHC for insurance benefit otherwise payable to me under terms of my policy but not to exceed the balance due to the organization furnishing the services performed during this period of treatment. In making this assignment, I understand and agree that I may be financially responsible to the above part and/or parties for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

Client Signature _____ Date: _____

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