Client Name: ____

Clinician Name: ____

Type of Service	Dollar Amount
Individual Therapy (30 Minutes) 90832	$ 102.00
Individual Therapy (45 Minutes) 90834	$ 143.00
Individual Therapy (60 Minutes) 90837	$ 212.00
Family Therapy (60 Minutes) 90847	$ 175.00
Group Therapy (60 Minutes) 90853	$ 65.00
D.E.E.P. Amount determined by counselor:	$_______________

My signature below acknowledges that I understand the above Fee Schedule. I also understand that this rate may be adjusted according to my insurance company's allowed amount.

Client Signature: ____ Date: ________________

Parent/Guardian Signature: __________________________________ Date: ________________

Clinician Signature: ____ Date: ________________