



Encounter Form / Super Bill

PATIENT NAME _____ MR# _____ DATE _____

FULL FEE WILL BE CHARGED FOR RESERVED APPOINTMENTS NOT CANCELLED WITH 24 HOURS ADVANCE NOTICE

DESCRIPTION	TIME	CPT CODE	Level I Therapist	Level II Therapist	Level III Therapist
Initial evaluation	Up to 55 mins	90792/90791	\$225	\$140	\$110
Individual psychotherapy	Up to 25 mins	99214/90832	\$110	\$65	\$45
	Up to 55 mins	99205/90837	\$185	\$110	\$85
Medical management	Up to 15 mins	99213	\$85	N/A	N/A
(Eval & Mngmnt) Suboxone Induction	60 mins	99204	\$225	N/A	N/A
(Eval & Mngmnt) Suboxone follow up visits	10 mins	99212	\$55	N/A	N/A
Group Psychotherapy	Up to 55 mins	90853	\$65	\$50	\$35
Psychological Testing	Per hour	96120 CNSVS 96103 MMPI-2	\$200 x ___ hrs	N/A	N/A
Telephone consultation	Up to 15 mins	99373	\$100	\$70	\$40
After hours OR complex OR emergency	Up to 55 mins	90839	\$175	\$100	\$65
Laboratory tests: EtG Alcohol screen 9 panel drug screen	Each test	80101	\$35	N/A	N/A
		80100	\$65		
30 min add on	Up to 30 mins	Use 90839 with 90840	\$275	\$160	\$105
Special reports/extended review of records	Each 30 mins	99050	\$150	\$100	\$100
Depositions in this office/meeting with atty.	Min. charge is 120 mins	99075	\$400 hr in adv	\$375 hr in adv	\$350 hr in adv
Depositions or court testimony	Min 4 hr	99075C	\$500 hr - 4hr min	\$300 hr - 4 hr min	\$250 hr - 4 hr min
Special reports	Each 30 mins	99050	\$150	\$100	\$75

- Level I: Sharon Freeman Clevenger, MA, MSN, PMHCNS-BC License # 70000153A / 70000153B
- Level II: Holly R. Lichtsinn, MSW, LCSW License # 34005538A
- Level II: Susan Schuereberg, MA, LMHC License # 39002498A
- Level II: Carmella Shick, MEd, LMFTA License # 8500124A
- Level III: Sarah Roberts Hoos, MS, MFT License # in process

- Acute Stress 308.3 ADD 314.00 ADHD 314.01 Adj D/O, Anx 309.24 Adj D/O, dep 309.0 Adj D/O, mixed 309.28
 Anorexia Nervosa 307.1 Antisocial P/D 301.7 Anx D/O NOS 300.00 Autism Spectrum 299.00 Avoidant 301.82
 Bipolar II 296.89 Bipolar I 296.4 Borderline PD 301.83 Bulimia/Binge eating 307.51 Caffeine intox 305.90
 Cannabis use D/O (mild 305.20)(severe 304.30) Circadian Rhythm D/O 307.45 Cocaine (mild 305.60)(severe 304.20)
 Cyclothymia 301.13 Delusional D/O 297.1 Dependent 301.6 Disruptive Mood Dysregulation 296.99 E.D. 302.74
 ETOH use D/O (mild 305.00)(severe 303.90) GAD 300.02 Histrionic 301.50 Hypersomnolence 780.54 Illness Anxiety 300.7
 Insomnia 780.52 Mild Neuro Cognitive D/O 331.83 Mjr Dep, recurrent 296.3 Mjr Dep, single 296.2 Narcissistic 301.81
 OC per D 301.4 OCD/Hoarding 300.3 ODD 313.81 Opiod use D/O (mild 305.50)(severe 304.00) OSA 327.23 Panic 300.01
 Paranoid PD 301.0 PMDD 625.4 Psych factors affecting med 316. PTSD 309.81 RLS 333.94 Schizoaffective 295.70
 Schizoid PD 301.2 Schizophrenia 295.90 Schizotypal PD 301.22 Sed. Hyp. Anxiolytic (mild 305.40)(severe 304.10)
 Sep Anx D/O 309.21 Social Anxiety 300.23 Somatic Sx D/O 300.82 Stim use D/O (mild 305.70)(severe 304.40)
 Tobacco use 305.1 Other _____ Other _____ Other _____

In consideration of the services rendered to me, I agree to be responsible for prompt, full payment of all fees regardless of third party liability. I agree to the release of Protected Health Information to my insurance company as needed to obtain payment for treatment. I am responsible for my outstanding balance at the maximum statutory rate, and for any applicable service fee. In the event any balance is referred for collection, I am responsible for attorney fees and court costs incurred.

Patients Signature _____ Date _____

Cash Check Visa MasterCard Disc Amex \$ _____ Ck # _____

Amount Due Today: _____ RTC _____