

**ICCBT**

INDIANA CENTER FOR COGNITIVE BEHAVIOR THERAPY

423 AIRPORT NORTH OFFICE PARK
FORT WAYNE, INDIANA 46825
260-969-5583; FAX 260-969-5584
WWW.ICCBT.ORG
EIN: 20-3091304**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 80100	\$35 \$65	N/A	N/A
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, MSED, 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 _____