Consciously Integrated Counseling
4284 William Flynn Hwy, Suite 304
Allison Park PA 15101
Phone: 412-245-7104 Fax: 513-672-9057
Email: ben@consciouslyintegrated.com

2024 Service Fee Schedule

Effective 8/7/2024

This fee schedule takes effect beginning 8/7/2024 and is updated at least annually. The next year's fee schedule is provided the first week of December during the calendar year that this schedule is in effect. I reserve the right to adjust fees at any point with 6-week notice to clients.

Payment for Services

Please indicate whether you prefer to use insurance or private pay for services. Clients wishing to use insurance to partially cover Ketamine-Assisted Psychotherapy (KAP) services or clients who expect to use a blend of private pay and insurance should check boxes for both Insurance and the appropriate Private Pay method. If insurance is selected below as a payment method, it will be considered the default payment method for all sessions *except* KAP Experientials and sessions which client provides advance notice that they wish for a session to be private pay.

Insurance:

____ I am requesting that my insurance provider be billed for services and am aware that this requires the diagnosis of a mental or substance use disorder to be treated. Clients who do not meet criteria for a mental or substance use disorder per DSM-V diagnostic criteria may be ineligible to use insurance for services. Please note that insurance can only partially cover KAP services (Preparation & Integration Sessions) and that KAP Experiential Sessions are only billed through private pay. I agree to pay any co-pays, coinsurance, or other cost-sharing charges associated with using my insurance.

Member Name: ________________________________
Policy Holder Name & Employer: ____
Insurer: ______________________________________
Member ID: ___________________________________
Group ID: _____________________________________

Private Pay:

____ I am requesting to privately pay for services and agree to CIC’s Standard Rate of $125/hour for therapy services.

____ I am requesting to privately pay for services but need a Sliding Scale or Pro-Bono rate. Please be aware that Sliding Scale and Pro-Bono spaces are limited and not all requests will be able to be honored. If these spaces are available, a separate form will be completed to determine your rate.

Consciously Integrated Counseling
4284 William Flynn Hwy, Suite 304
Allison Park PA 15101
Phone: 412-245-7104 Fax: 513-672-9057
Email: ben@consciouslyintegrated.com

Sliding Scale - Only applicable to Private Pay

Please read the following descriptions and identify which most closely matches your own financial situation. Enter this "locale" and a rate close to what is recommended below after reading.

1) Locale 1 – Standard Rate $130
a. I am able to comfortably meet all of my basic needs (e.g. food, transportation, housing)
b. I may have some debt but it does not prohibit attainment of basic needs
c. I outright own or pay a mortgage on a home or property OR rent a higher-end property
d. I own or lease a car
e. I am employed, self-employed, or do not need to work to meet my needs
f. I have access to financial savings, family wealth, and/or resources in times of need
g. I have an expendable income (e.g. can buy coffee or tea as I like, can go to movies, buy new clothes, etc. on a regular basis)
h. I can buy things when I need them
i. I can take vacations or take time off for leisure without financial burden

2) Locale 2 – Recommended rate $90
a. I am able to meet my basic needs
b. I may have some debt but it doesn't prohibit attainment of basic needs
c. I can afford to live in a house or apartment that is comfortable and safe
d. I own or lease a car or can afford other daily reliable transportation
e. I am employed or self-employed
f. I have access to health care
g. I have access to some financial savings for emergencies
h. I have some expendable income
i. I can take time off for sickness or leisure and am still able to pay next month's bills
j. I can afford to take a vacation annually or every few years

3) Locale 3 – Recommended rate $60
a. I may stress about meeting basic needs & don't always have a way to achieve them
b. I have some debt
c. I am employed or self-employed but work part-time or gigs to try and make ends meet
d. I have limited or no financial savings
e. I have limited access to health care or sometimes avoid going to the doctor because I can't afford the extra expense
f. I have limited expendable income

Consciously Integrated Counseling
4284 William Flynn Hwy, Suite 304
Allison Park PA 15101
Phone: 412-245-7104 Fax: 513-672-9057
Email: ben@consciouslyintegrated.com

g. I usually thrift rather than buying new things that I need
h. I have to actively save in order to take time off work
i. I own a car but struggle to cover insurance and maintenance. If I don't own a car, I can still access other forms of reliable transportation

4) Locale 4 – Pro-Bono
a. I frequently stress about meeting basic needs & don't always achieve them
b. I have debt and it sometimes prohibits me from meeting basic needs
c. I rent lower-end properties or have unstable housing
d. I do not have a car and/or have limited access to a car and gas. I cannot always afford or access other forms of transportation
e. I am unemployed or underemployed
f. I qualify for public aid including food assistance and health care
g. I have no financial savings
h. I have no or very limited expendable income
i. I rarely buy new items because I am unable to afford them
j. I cannot afford a vacation or do not have the ability to take time off without financial burden.

Based on the above descriptions, my life most closely resembles Locale _____ and I am requesting a rate of $_____/hour.

Superbills

If you selected a Private Pay option above, please indicate whether or not you would like to receive Superbills. Superbills are documents which you may submit to your insurance company to request reimbursement for services you have already paid for. Please note that *superbills require the diagnosis of a mental or substance use disorder which may become a part of your medical record.*

While I am happy to provide you with this documentation, I am neither able to assist in the submission of these claims nor guarantee their reimbursement. Clients wishing to submit superbills for reimbursement may contact their insurance companies to determine benefits for out-of-network providers using the billing codes CPT 90791 (Psychiatric diagnostic evaluation) and 90837 (Psychotherapy, 50 minutes). KAP Experiential sessions are listed on Superbills but are unlikely to be reimbursed by insurance companies due to the novelty of the treatment and lack of insurance billing codes for the service.

Superbills may not be submitted to Medicaid, Medicare, or Tricare due these programs' contracts with their clients/patients. Client submission of superbills to these insurers may result in termination of services.

Consciously Integrated Counseling
4284 William Flynn Hwy, Suite 304
Allison Park PA 15101
Phone: 412-245-7104 Fax: 513-672-9057
Email: ben@consciouslyintegrated.com

Please indicate below whether you would like to request monthly superbills for services:

○ Yes, I would like a superbill provided every month.

○ No. I agree to let my provider know if I change my mind and understand that this request cannot be retroactively applied to past services.

Additional Services:

1. **Subpoena for court**- $425/ hour or $1700 (minimum) to cover the four- hour usual and customary charge, to be paid in full prior to court date appearance. This fee involves: clinician need to clear schedule, preparation time involved, transportation, waiting time, and attendance to legal proceeding. If proceedings are longer than 4 hours, $400 will be added per each additional hour of time. All payments for court appearances are due 48 hours prior to scheduled time and date, and no later than noon on Thursday if the court proceedings are scheduled for Monday. I reserve the right to terminate the therapeutic relationship and refer out to other mental health providers especially when clinician has indicated that s/he does not attend court and/or is subpoenaed when asked not to.
2. **Report/ Letter/ Assessment-** Remit customary $125/ hour, towards time spent doing research and writing of document, to be paid for prior to obtaining report.
3. **Phone calls/ Email Correspondence-** Remit $125/ hour, $63/ half hour, or $32/ fifteen min, spent on the phone or involved in email collaboration/ consultation with clinician, paid for prior to call, with begin time and end time already determined.
4. **Out of Office Meetings-** (To include: team mtgs, IEP mtgs, hospital meetings, meetings with attorneys or MDs, and/ or other types of CPST mtgs, and so on)- Remit $125/ hour, to be paid for prior to appointment. Time spent transporting to and from the indicated location may hold additional costs and are to be determined by the clinician.

Late Cancellation & No-Show Fees:
I ask that you provide at least 24 hours' notice if you need to cancel any appointment. If you do not arrive within 15 minutes of your scheduled appointment time and have not provided notice, I reserve the right to cancel your session and consider it a no-show.

If you late cancel or do not show for **a one-hour therapy appointment**, you will incur a $50 fee beginning with the second late cancel or no-show in any given 12-week period.

If you late cancel any **three-hour KAP Experiential appointment**, you will incur a $150 fee. If you no-show one of these appointments, you will be responsible for 100% of the cancelled session's original fee.

Consciously Integrated Counseling
4284 William Flynn Hwy, Suite 304
Allison Park PA 15101
Phone: 412-245-7104 Fax: 513-672-9057
Email: ben@consciouslyintegrated.com

If you are able to reschedule a late-cancelled or no-show session during the same calendar week as the missed appointment, you will only be charged 50% of fee incurred.

By Signing My Name Below:

- I agree that I have read and understand the costs associated with receiving therapy services
- If I indicated that I wished for insurance to be billed, I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the therapist.

____ _____________________________________
Signature Printed Name
Date: _____________