Alyssa M. Revuelta, PhD
Licensed Clinical Psychologist
523 Live Oak Drive
Mt. Pleasant, SC 29464

Fee Schedule

Psychotherapy	
Initial 60-minute consultation with parent(s)	$200
Initial 60-minute session with patient	$200
50-60 minute session	$175
40-45 minute session	$150
30-minute session	$100
Psychological Testing	
Per each hour of time (includes administering, scoring, and report writing)	$175
Deposit due on day of testing (with remaining balance due at feedback session)	$300
Psychological Evaluation for Immigration Proceedings	$600 ($300 deposit due on date of session remaining balance due with report)
Other Professional Services	
Per hour rate	$175

** These services include report writing, telephone conversations exceeding 15 minutes, consulting with other professionals with your permission, school observations/consultations with your permission, preparation of records or treatment summaries, attendance at school meetings, and time spent performing any other specific service you may request.

FEE AGREEMENT

Unless other arrangements are made, fees are as listed and are due at each session or at the time service is rendered. I am unable to submit insurance claims but will provide you with the necessary documentation and guidance to file claims with your insurance provider. **The full session fee will be charged for missed appointments cancelled less than 24 hours in advance.** Insurance companies will not reimburse for missed appointments.

I have read, understand, and agree to the above. I agree to accept the services of Alyssa M. Revuelta, Ph.D. and to accept the fees for those services as lawful debt. I agree to pay said fees as outlined above. This includes an agreement to pay costs of collections, attorney fees, and court costs, if necessary. I waive now and forever the right to claim exception under the Constitution and laws of the State of South Carolina or any other state. I also understand that failure to pay these fees may result in release of my name, known phone numbers, and addresses, other information during the collection process.

Permission for Treatment or Services

Permission is hereby given to Alyssa M. Revuelta, Ph.D. to render treatment and/or service to

_____ whose relationship to me is ___ Self ___ Child ___ Other (Specify: _____)

Your Signature: _____ Date: _____

Provider Signature: _____ Date: _____