Patient's Name

I have been given a copy of "Patient Rights."

Signed _____ Date

Davis Psychological Services Consulting, PLLC Sliding Fee Schedule per Unit = 50 minutes						
Gross Annual	Gross Weekly	Diagnosis/ Assessment	Neuropsy-chological	Psycho-logical	Therapy	
0-9,999	0-192	50	75	70	25	
10-14,999	193-288	55	80	75	30	
15-19,999	289-385	60	85	80	35	
20-24,999	386-481	65	90	85	40	
25-29,999	482-576	70	95	90	45	
30-34,999	577-673	75	100	95	55	
35-39,999	674-768	85	110	100	60	
40-45,999	769-884	95	120	110	65	
45-49,999	885-961	105	130	120	70	
50-54,999	962-1057	125	140	130	75	
55-59,999	1058-1153	140	150	140	85	
60,000+	1154+	200	200	200	95	

I understand my ability to pay for services has been determined to be $ _____ per visit. This fee is in addition to any insurance benefits that might be available when insurance covers less than the full cost of services. Fees are payable at the time service is rendered, if insured, I understand I am responsible for my co-pay, if any and that I will pay my co-pay at time of service.

Signed Date