FEE SCHEDULE & FINANCIAL ACKNOWLEDGMENT

Genevieve Williamson, MD
1800 Old Pecos Trail, Suite B
Santa Fe, NM 87505

This document outlines the fees for services provided by Dr. Genevieve Williamson, MD. Professional time and expertise are billed according to the schedule below. Fees may be adjusted periodically; patients will be notified in advance of any changes.

Genevieve Williamson, MD does not accept insurance, and all charges will be directly billed to client at time of service. You must maintain a card on file. The practice will not send statements or bills directly to your insurance. Monthly superbills will be provided to you, which you can send to your insurance for possible reimbursement. The practice is not responsible for determining whether or not services are covered by your insurance.

Appointment-Based Services

Initial Evaluation
Duration: 90 minutes
Fee: $500

Follow-up Medication Management Visit
Duration: 30 minutes
Fee: $200

Follow-up Psychotherapy Session
Duration: 45–60 minutes
Fee: $250 - $300

Family Psychotherapy Session
Duration: 75 minutes
Fee: $300

Additional Professional Services

These services require time outside of scheduled appointments and will be billed in increments of **15 minutes** at the rate of **$75 per increment** with a minimum of 1 increment, unless otherwise specified. Insurance typically does not reimburse for these services, and payment is the patient's responsibility.

Neurodevelopmental Evaluations (Autism, ADHD, etc)

These services require additional expertise, use of proprietary assessments, and additional time inside and outside of scheduled appointments. Costs for these evaluations are case dependent, and can range from $1,000-$5,000.

Comprehensive Written Evaluations
(e.g., psychiatric summaries, school evaluations, disability evaluations)
Fee: $300 per hour, minimum of 1 hour, may increase based on length and complexity

Letters and Written Documentation
(e.g., letters to schools, employers, legal counsel, housing authorities, emotional support animal requests)
Fee: $300 per hour, minimum of 1 hour, may increase based on length and complexity

Phone Consultations Longer Than 10 Minutes
(including calls with family members, attorneys, schools, or other providers)
Fee: $75 per 15-minute increment, minimum of $75

Care Coordination / Professional Collaboration
(communication with other clinicians, teachers, or agencies that exceeds brief administrative contact)
Fee: $ 75 per 15-minute increment

Form Completion
(e.g., FMLA, disability, academic accommodation, return-to-work forms)
Fee: $300 minimum; additional fees may apply based on complexity

Medication Prior Authorizations
(only if insurer requires extensive documentation)
Fee: $ 75 per 15-minute increment

Medical Records Requests
Fee may apply pursuant to state guidelines for retrieval, copying, and administrative processing
Fee: $ 50

Missed Appointment / Late Cancellation Fee
Applies when notice is not received within 48 hours of appointment start time, or if patient appointment is cancelled due to arriving more than 10 minutes late for a scheduled appointment.

Fee: Full cost of services (varies based on appointment type, see Appointment Based Services above). *Insurance will not reimburse this fee, please make every effort to be on time or cancel within 48 hours of appointment start time to avoid paying this fee.*

Payment Terms

- Payment for services is due at the time of appointment unless otherwise arranged.
- Charges for services rendered outside of appointments will be billed to the patient and must be paid before further services are scheduled.
- The practice may securely store a payment method on file for convenience and unpaid balances.
- Services may be suspended or terminated for unpaid balances.

Acknowledgment and Signature

By signing below, I acknowledge and agree to the following:

- I have reviewed and understand this Fee Schedule.
- I understand that charges for services outside of scheduled appointments are my responsibility.
- I understand that Genevieve Williamson, MD does not accept insurance, and will not send receipts directly to my insurance for reimbursement.
- I understand that I am responsible for submitting receipts for services rendered to my insurance company.
- I agree to pay for services at the listed rates and understand that insurance may not reimburse these fees.
- I agree to notify the practice of any changes in my contact or billing information.

Patient Name: _____
Date of Birth: _____

Signature: _____ Date: _____

Responsible Party Name (If not being signed by patient): _____