BLUE RIDGE BEHAVIORAL HEALTH
170 Thomas Johnson Drive, Suite 200, Frederick, MD 21702
Phone: 301-695-8390 / Facsimile: 301-694-7906

NOTICE of FEES

The fees effective January 1, 2026 are as follows:

Neuropsychological Testing

Evaluation $225 - $450

Patients are scheduled for one or two 60 minute evaluation appointments for neuropsychological testing at a rate of $225 per hour, with total evaluation appointment fees of $225 or $450, respectively.

Testing Code	Fee Per Unit	Quantity	Expected Fee
96132	$220	1	$220
96133	$220	3 - 4	$660 - $880
96136	$110	2	$220
96137	$110	10 - 14	$1,100 - $1,540

Total for Evaluation and Testing: $2,425 – $3,310

*There is an additional $500 fee for learning disability testing that is not covered by insurance when neuropsychological testing is completed only for educational or vocational purposes. This is not included in the estimated fees noted above.

Other Fees:
All charges listed under Other Fees are not subject to insurance reimbursement and are the responsibility of the patient.

Twenty-four business hours' notice, excluding weekends and holidays, is required to cancel or reschedule any appointment. Missed appointment fees for neuropsychological testing are as follows: $225 for an Evaluation or Feedback appointment; $337.50 for a Testing appointment.

Psychologists charge $225 per hour, rounded to the nearest 15 minute interval, for school or team conferences, consultations conducted by telephone, time spent reviewing outside records, and time spent preparing and/or writing forms, reports or letters. Writing and preparing the neuropsychological testing report is excluded from this additional fee. The charge for legal or court related services is $450 per hour rounded to the nearest 15 minute interval.

Per Maryland law, the fee for copying patient medical records is 76 cents per page plus the actual cost of postage and handling. There is an additional preparation fee of $22.88 that will only be charged if medical records are transferred to a person or entity other than the patient or patient's personal representative.

Fee Adjustments:
Adjustments in fees will occur every 3 years.

By signing below, I acknowledge and agree to the fees for services.

_____ _____
Printed Name of Patient **Date**

_____ _____
Signature of Patient or Parent/Guardian **Date**