MAKRINOS MENTAL HEALTH COUNSELING SERVICES, LLC

CLIENT RIGHTS AND RESPONSIBILITIES

TREATMENT INPUT/PARTICIPATION:
You are an integral part of your treatment and have the right to ask questions at any point. You may request and negotiate therapeutic goals, and you may refuse to participate in any intervention, strategy or behavior suggested by your therapist. You have the right to be fully informed regarding the therapist's estimation of approximate length of therapy to meet your goals. You have the right to terminate treatment at any time. A termination session may be suggested in order to discuss progress made or continuing areas of concern. Every effort will be made to tailor treatment to your individual needs. You have the right to be fully informed about your therapist's qualifications, training and experience and you may ask questions about his/her clinical orientation.

FINANCIAL POLICY:
The fee for an initial diagnostic assessment is $175 and a standard 45-minute follow-up appointment is $150. Psychological evaluations, testing, and reports are billed at a rate of $200 per hour, and this fee will be discussed in advance with this therapist. Ancillary professional services are charged at a rate of $150 to $250 per hour and are not to be covered/reimbursed by insurance (e.g., consultation with other professionals or agencies, court appearances, depositions, subpoenas, preparation of reports and case related correspondence, telephone calls, etc.) There will be an additional fee for all insurance forms to be filled out. Please allow 10 days for this to be completed.

PAYMENT IS EXPECTED AT THE DATE OF EACH SERVICE.

IF YOU HAVE HEALTH INSURANCE, PLEASE UNDERSTAND THAT THIS IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. IF YOUR INSURANCE COMPANY REQUIRES AN AUTHORIZATION FOR YOUR INITIAL VISIT(S), PLEASE MAKE SURE THAT YOU HAVE OBTAINED THIS AUTHORIZATION NO LATER THAN YOUR FIRST VISIT. IF YOUR INSURANCE COMPANY DENIES YOUR INITIAL VISIT(S) BECAUSE OF NO AUTHORIZATION YOU WILL BE RESPONSIBLE FOR FULL PAYMENT FOR THESE VISIT(S). IF, HOWEVER, YOUR INSURANCE COMPANY DOES NOT PAY THE ANTICIPATED AMOUNT, YOU ARE STILL RESPONSIBLE FOR THE TOTAL AMOUNT OF THE BILL.
BY SIGNING BELOW YOU ASSUME COMPLETE RESPONSIBILITY FOR ALL TREATMENT COSTS NOT COVERED BY YOUR INSURANCE PROVIDER(S).

Please be aware that the insurance benefits quoted by your insurance company are not a guarantee of payment and are subject to change. In the event your account is not paid in a timely manner, this may be reported to a credit-reporting agency. In the event your account is past due by 90 days or the balance exceeds $1000, collection proceedings may be instituted.

FEES:
A $30 fee will be charged for returned checks. We may use electronic withdrawal from your account for the amount of the check plus the $30 returned check fee, if a check is returned for insufficient funds. Interest will accrue at the rate of 1.5% per month on any portion of your bill that is over 90 days past due. If we have to refer the collection of your account to a lawyer or collection agency, you will be responsible for all costs of collection, including reasonable collection agency fees, attorney's fees and court costs.

CANCELLATION / NO SHOW POLICY
A 55 minute session is reserved exclusively for you at the time you setup your appointment. If you must cancel an appointment please do so at least **48 hours in advance**, or you will be charged a late cancellation fee of the allowed amount of the 55 minute session as determined by your insurance provider (full cost will be allocated for self-pay clients.) **These charges cannot be billed to insurance and are due immediately.**
Note: *These charges will apply regardless of whether you have received optional Email Notification for your appointment. An answering service is available to take your after-hours calls.*

Initial ________________________
I have read, understand and agree to abide in full by all statements listed in this document.

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Client Signature (or Parent (guarantor), if minor) ***Date Signed***