MAKRINOS MENTAL HEALTH COUNSELING SERVICES, LLC

3268 Jefferson Avenue, Cincinnati, OH 45220-2220
Phone: (513) 708-8188 cell – (513) 677-6624 FAX
MMHCS @ fioptics.com
www.makrinosmentalhealth.com

SELF-PAY FEE AGREEMENT

This document declares that I, ____

Agree to be responsible for paying in full the amounts listed below for services:

Diagnostic Interview: $___________ per hour ____________
Client Initials

Individual Psychotherapy: $___________ per hour____________
Client Initials

No-Show/Late Cancellation*: $___________ per hour____________
Penalty Fees Client Initials

This Fee Agreement is in effect as of _______________ ____________
Client Initials

** This $ amount if left blank is the same as Individual Psychotherapy unless otherwise specified*

I understand this arrangement will be in effect for **all services for which MMHCS is not accepting client's Health Insurance or Health Insurance does not or will not cover services.**
I understand this to be in effect without exception.

By signing below I understand and agree the terms specified in this document will take precedence over any other previous arrangements as of the date signed.

By signing below I agree to the terms specified in this document and understand that MMHCS will take any legal action to collect unpaid debt in its entirety.

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_________________________	___________	_________________________	___________
Client Signature	Date	Clinician Signature	Date
_________________________	___________	_________________________	___________
Parent/Guardian Signature	Date	Supervisor Signature (if applicable)	Date

If you have any questions, please contact us at (513) 708-8188

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