Midwest Psychiatric Center, Inc.
Dr. Rakeshkumar Kaneria, M.D.
Leah Fogt, LISW-S, CTP
7760 West VOA Park Dr., Ste. G West Chester, OH 45069 Phone: 513.217.5221 Fax: 513.217.6221

Self-Pay Agreement for Psychotherapy

I, _____ (DOB:_____) certify that I am electing to pay for psychotherapy services myself, rather than utilizing a medical insurance policy to cover all or part of the expense of my care.

I understand that my fee is payable at the beginning of each session according to the table below, unless other arrangements have been made prior to the appointment.

Service Description	Billing (CPT) Code	Standard Charge	Self-Pay Discount	Self-Pay Charge
Diagnostic Session	90791	$ 195.00	23% off	$ 150.00
Full Therapy Session (50-60 Minutes)	90837	$ 180.00	33% off	$ 120.00
Short Therapy Session (45 Minutes)	90834	$ 110.00	24% off	$ 84.00

I further understand I will not be charged for any psychotherapy appointments that are cancelled at least 24 hours in advance. I understand appointments not cancelled at least 24 hours in advance are subject to a $50.00 missed appointment charge, as are no-show appointments.

I agree to pay all fees and missed appointment charges before the beginning of the next session.

I understand that I am solely responsible for all applicable charges, late cancellation, and no show fees, include the costs of collecting such fees, including but not limited to interest on any amounts due and owing and reasonable attorney fees.

I further acknowledge that my therapist or any member of Midwest Psychiatric Center staff may verbally review my account with me. Should I desire to initiate use of a health insurance policy as payment for psychotherapy services, I agree to disclose my intent and the insurance policy information prior to the first session to be covered by insurance, though co-pays, coinsurance, and deductibles will apply according to my insurance policy.

CLIENT PRINTED NAME: _____

CLIENT SIGNATURE: _____ DATE: _____

THERAPIST PRINTED NAME: LEAH FOGT, LISW-S, CTP

THERAPIST SIGNATURE: _____ __ DATE: _____