Office Consultation Fee for Services

I am in agreement to pay Metamorphosis Psyche, LLC an in-office consultation fee for services in the amount of $25.00 for all initial and follow-up evaluations. This fee is in addition to any copay and/or coinsurance amounts, if applicable. Payment is due on the day of my appointment at least 15 minutes prior to the scheduled appointment.

Note: This in-office consultation fee **is included** in quoted payment rates **for self-pay clients**.

______________________________ ____/___/_____
Patient's Name (Printed) **Date of Birth**

____
Parent/Guardian's Name (if applicable)

__________________________ ___/___/______
Patient/Guardian's Signature **Today's Date**

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