Mark Kaplafka Counseling, LLC
20545 Center Ridge Road, Suite125
Rocky River, OH 44116

# CLIENT ELECTION TO SELF-PAY FOR SERVICES

I,_____ , the undersigned client, acknowledge that I understand and agree that:

1. Mark Kaplafka Counseling, LLC is not an in-network provider with my insurance health plan.

2. The health plan under which I am covered may include benefits for the services provided by my therapist.

3. Despite the above, I do not want Mark Kaplafka Counseling, LLC to submit a claim to my insurer for services provided to me.

4. I elect to self-pay for all services I receive from Mark Kaplafka Counseling, LLC

5. By election to self-pay for services, any payments I make will not be credited toward satisfying any deductible I may have under my health insurance plan.

6. By electing to self-pay, I agree I will only submit a receipt, proof of payment, a superbill or invoices for services or any proof of payments for services received from Mark Kaplafka Counseling, LLC to my insurance company for reimbursement if Mark Kaplafka Counseling, LLC is not an in-network provider with my specific insurance plan.

7. I have read this election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.

8. I have freely chosen to self-pay for services after having asked Mark Kaplafka Counseling, LLC about payment options and having carefully considered those options.

_____ _____

Client Signature Date

_____

Print Name