PSYCHOLOGICAL SERVICES ACKNOWLEDGMENT FORM | MAPLEWOOD PSYCHOLOGY

The purpose of this form is to obtain your consent to administer care and to share your health and personal information as necessary to process bills or claims, carry out functions that support treatment, and coordinate your care with other providers.

RESPONSIBILITY FOR PAYMENT

			Initial
(1)	I agree to pay my copay at each session and understand I am ultimately responsible for payment for services received after insurance has processed claims (deductible and patient portion). I will notify the clinic if there are any changes in my health insurance coverage, home address, or phone number. I accept that I am responsible for Other Professional Services fees that are not covered by my insurance company if requested or required.	(1)	
(2)	I hereby authorize Maplewood Psychology to furnish to my insurance company all information that my insurance company may request concerning my present illness. I hereby assign to Maplewood Psychology the insurance proceeds to be credited against the total fee for services due on my account. I authorize Maplewood Psychology to correspond with the responsible party I designate regarding any outstanding balance due on the account.	(2)	

CANCELLATIONS AND MISSED APPOINTMENTS

(3)	I understand and agree to the 24-hour cancellation and missed appointment policy and accept responsibility for the fee of $100.	(3)	

EMERGENCY POLICY

(4)	I understand that I can reach a therapist by calling the office during business hours, or by calling the answering service after business hours. I understand if my therapist is not available or on vacation, the on-call therapist will respond to my emergency.	(4)	

ELECTRONIC COMMUNICATION POLICY

(5)	I have been informed of the office policies regarding electronic communication and will abide by its tenets.	(5)	

CONFIDENTIALITY

(6)	I have read and agree to the LIMITS OF CONFIDENTIALITY and understand their meanings and ramifications.	(6)	

CONSENT FOR TREATMENT

(7)	I authorize my therapist to administer care and treatment to me, and to perform diagnostic procedures and tests or other treatment considered necessary and advisable by my therapist. I understand there is a cost involved with these diagnostic procedures, assessment tools, and tests, and I am responsible for any portion not paid by my insurance company.	(7)	

My initials and signature on this form, to be filed in my clinical record, indicate that I have read and understood the Psychological Services Agreement regarding office policies, psychological practices, privacy practices, and confidentiality, and I give my informed consent to receive clinical services.

_____ _____ _____

Signature of Client or Client Representative **Printed Name** **Date**