JOY PICCOLINO, PSY.D.

Licensed Psychologist

ACKNOWLEDGEMENT FORM

Please initial each item to indicate your acknowledgement of the statement, then sign and date at the bottom.

_____ I have read the **PSYCHOLOGIST-PATIENT SERVICE AGREEMENT** and agree to abide by its terms during our professional relationship.

_____ I have received the **HIPAA NOTICE** form.

_____ I have read and understood the **BILLING AND COLLECTION POLICIES** and I agree to abide by its terms. I understand that even if I have insurance and Joy Piccolino, Psy.D., LP assists me in collecting from my insurance company, responsibility for my account remains my own.

_____ I have been informed of the cancellation/missed session policy requiring 24-hours notice to avoid being charged.

_____ I have read and understood the **SOCIAL MEDIA POLICY**.

_____ I further authorize and request that Joy Piccolino, Psy.D., LP carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my (my minor child's) care are advisable. I understand that the purpose of these procedures will be explained to me (my minor child) upon request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

_____ _____
Signature of patient Date

_____ _____
Signature of parent/guardian if minor Date

_____
Relationship to patient

_____ _____
Joy Piccolino, Psy.D., Licensed Psychologist Date

Rev. 6/10