Joy Piccolino, PsyD
Licensed Psychologist

Acknowledgement Form

Client Name _____ DOB _____

CONSENT FOR TREATMENT: I consent to treatment and agree to abide by the policies and agreements with Joy Piccolino, PsyD, LP, as stated in the Client Services Agreement.

ACKNOWLEDGEMENTS

- CLIENT RIGHTS AND DATA PRIVACY: I have received and read the Client Services Agreement and HIPAA Notice form.

- ASSIGNMENT OF INSURANCE BENEFITS: I the undersigned, certify that I have insurance coverage as noted in the Client Registration and assign directly to Joy Piccolino, PsyD, LP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Joy Piccolino, PsyD, LP to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

- CANCELLED/MISSED APPOINTMENTS: I understand that if an appointment is missed or cancelled with less than 24-hours notice, I will be billed directly according to the scheduled fee or according to the rules of my insurance plan. Repeated cancellations and missed appointments may result in termination of the therapeutic relationship. A letter reflecting termination will be mailed to you should this occur.

- AUTHORIZATION FOR COMMUNICATIONS VIA TEXT OR EMAIL AND ACKNOWLEDGMENT: Per HIPAA regulations, you have the right to receive communications via text message and/or non-secured email from Joy Piccolino, PsyD, LP, if you choose. These messages will be used for scheduling, logistics, and administrative purposes only. Before considering using non-secured email or text communication be advised that text messaging and nonsecure email messaging is an unencrypted conversation that has the potential to be read by a third party. Your cell service carrier rates will apply to communications via your cell phone. Joy Piccolino, PsyD, LP is not responsible for any charges you may incur. Please initial one:

  I DO consent_____ Email address:_____

  I DO NOT consent_____

- COURT COSTS: I understand that if Joy Piccolino, PsyD, LP is required, by subpoena or other means of summoning, to appear in court on my behalf that I will be responsible for a fee for all time and costs associated, including but not limited to deposition time, attorney meetings and calls, travel time, preparation time, research, costs for copying records, time in court, etc. Because of the difficulty of legal involvement, I charge $430/hour (portal to portal), with a minimum of 2 hours.

- EMERGENCY CONTACT: In case of emergency, Joy Piccolino, PsyD, LP is authorized to contact the following person for the purpose of assessing client safety or whereabouts or obtaining other emergency information. Clinical information will not be released unless necessary to confirm or assess safety.

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

By signing below, I consent to treatment and understand and agree to the policies and terms outlined above and in the Client Services Agreement. This document is subject to regular updates.

Client Signature: _____ Date: _____

Printed Name: _____