Psychological Associates of Southeastern Massachusetts, LLC
115 Main Street, Suite 2D, North Easton, Massachusetts 02356
Phone: 508-238-7766; FAX: 508-230-5089

Client Acknowledgment Form

My signature on this form indicates that I have received Psychological Associates "Office Policies" statement and the "Notice of Privacy Practices".

I acknowledge my understanding of and willingness to comply with the following office policies:

- late cancellation and missed appointment charges
- returned check fees (fees from both Psychological Associates and banks)
- 10% charge on 30 day overdue balances

I understand that I am responsible to inform my clinician immediately about insurance and billing changes. I understand that I must pay for staff time spent making billing adjustments as a result of my not informing Psychological Associates of changes. Fees for staff time are billed at $30 per hour.

I understand that delinquent accounts are sent to collections, and are subject to a 30% collections fee which the collections agency charges Psychological Associates.

I understand that clients with delinquent accounts may be offered services to avert emergencies or to assist in a crisis but are not offered regular follow-up visits. To be removed from a delinquent account, the full balance and 30% collections fee must be paid in full.

I understand this Client Acknowledgment Form applies to any and all clinicians I see here at Psychological Associates.

I acknowledge that I have received a signed copy of this form.

Client Signature_____ Date_____

Print Name_____

Client Signature_____ Date_____

Print Name_____

Signature of Responsible Party (if not the same as client)

_____DOB: _____ SS # or Lic. #_____

Print Name_____Date: _____

Psychological Associates witness_____ Date_____