ACKNOWLEDGEMENTS

PRINTED NAME: _____

PRIVACY PRACTICES

I have heard the overview of the privacy practices for ABC Psychiatric Services. The exceptions to maintaining confidentiality have been explained to me and I have received a full copy (either hardcopy or download) of the notice of Privacy Practices. If I have any questions at any time, I will bring them to the attention of my clinician at ABC Psychiatric Services.

SIGNATURE: _____**DATE:** _____

BILLING PRACTICES

I understand that fees incurred for professional services at ABC Psychiatric Services are my sole responsibility and payable at the time of service. I understand that if insurance claims are to be filed, ABC Psychiatric Services will provide necessary information about services rendered and fees collected, however the filing of these claims are my responsibility. In addition, I understand that missed or cancelled appointments with notice less than 1 business day may be charged at the full fee.

SIGNATURE: _____**DATE:** _____

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(718)261-3232