Stacey L. Maples
Licensed Psychologist

1407 S. Elliott
Aurora, MO 65605

417 440 0826
Fax: 888 602 7956

Acknowledgement of Agreements

Please initial to show that you understand the following then sign at the bottom of the form:

___ I have been provided or have been offered but declined a copy of this practice's current privacy policy. Any questions I had have been addressed.

___ I understand that financially I am responsible for payment of the bill and that filing of insurance by the office is a courtesy to me. I am responsible for payment of services and copayments. I further understand that unpaid balances more than 90 days overdue will possibly be turned over to collections without further notice to me if I have not made steps to become current on the account. If this occurs, I acknowledge that I will also be responsible for payment of additional fees—including a 1.5% per month (18% per year) service charge, collection fees, attorney fees, and court fees that will arise.

___ I understand this office's policy on missed appointments. Specifically I acknowledge that I need to provide 24 hour notice on missed appointments. Failure to do so when there is not an emergency may result in a Missed session charge at the FULL HOURLY RATE. Missed session charges are NOT covered by ANY Insurance and will be my own responsibility.

**We are testing a new online appointment tool which would allow you to adjust your appointments. If you would like to register for this service, please include an email address that you want to associate with this account. We will ONLY use your email to send a welcome email so that you can register online for access to the Patient Portal.

Email: _____ (please print clearly)

Signature: _____ Date:

Printed Client Name:

Witness: _____