Joseph L. Nines, Ph.D., L.M.F.T.
Licensed Marriage and Family Therapist
215-836-4276

CONSENT TO TREATMENT FORM

This form, as well as all other information, will be kept confidential and will not be released without your written consent. This information is necessary to complete your file and provide for payment by you or your insurance company. Your insurance provider may have some limited access to your records for billing and quality control purposes.

Name(s) _____ Age*: _____

* For clients under the age of 18, a Parent or Legal Guardian is authorized to sign for that client.

Date of Birth: _____ Referred by: _____

Member ID#: _____ Insurance Company: _____

Address:_____

Main Phone: _____ Home Email: _____

Cell Phone: _____ Work Email: _____

Joseph L. Nines may leave messages at these numbers: ☐ Main ☐ Cell ☐ Emergency
Joseph L. Nines may send email messages to these email addresses: ☐ Home ☐ Work

EMERGENCY CONTACT

In the event of an emergency, I/We authorize Joseph L. Nines to contact the person below

Name _____ Phone: _____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I/We, the undersigned, agree to be in therapy with Joseph L. Nines. I/We understand that I/We may refuse treatment at any time, which would require the closing of the file.

In exchange for professional services, we agree to pay Joseph L. Nines $125.00 per 50-minute session. It is my/our responsibility to make sure that I/We qualify for any form of insurance coverage. If the insurance company provides for out of network reimbursement, I/We agree to pursue that reimbursement from the insurance company directly. Joseph L. Nines sole responsibility is to provide a receipt or "superbill" for us to file with the insurance company. **I/We also understand that a 24-hour notice is required for cancellation of an appointment, or I/We will have to pay a $60.00 fee for the missed appointment.** I/We also understand that the fee stated above is payable to Joseph L. Nines on the day of services provided.

Any clinical information will be kept confidentially on file and may be destroyed seven (7) years after termination of treatment. I/We acknowledge that I/We have received the document entitled **Notice of the Policies and Practices to Protect the Privacy of Your Health Information, Cancellation Policies and Limits of Confidentiality** and have had my/our rights as a client/clients explained to me/us by Joseph L. Nines.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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CANCELLATION POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client. A cancellation fee of **$60.00** is charged for missed appointments or cancellations with less than a 24-hour notice, unless it is due to illness or an emergency. Below is an authorization for Joseph L. Nines to charge your credit card for missed appointments. This authorization will be kept in your file for the duration of your treatment. A receipt will be mailed directly to you after this charge has been placed. Thank you for your consideration regarding this important matter.

CREDIT CARD AUTHORIZATION

By signing below, I authorize Joseph L. Nines to charge the following credit card in the amount of **$60.00** for any appointment missed or cancelled without a 24-hour notice to Joseph L. Nines. I understand that missed appointments can happen due to illness and/or emergency and that Joseph L. Nines may waive this fee at his discretion.

Credit Card Type: ☐ VISA ☐ MasterCard ☐ DISCOVER ☐

CC #: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Security Code: _____ Expiration Date: _____/_____

Billing Zip Code: _____

Cardholder Signature: _____

Date: _____