Joseph L. Nines, LLC

Joseph L. Nines, PhD, 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 and/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 14, a Parent or Legal Guardian is authorized to sign for that client.

Date of Birth: _____ Referred by: _____

Address:_____

Cell Phone: _____ Other Phone: _____

Preferred Email Address: _____

Secondary Email Address: _____

Joseph L. Nines may leave phone messages and send email and text messages to these phone numbers or email addresses: ☐ Cell Phone ☐ Other Phone ☐ Preferred Email ☐ Secondary Email

EMERGENCY CONTACT

In an emergency, I/We authorize Joseph L. Nines, LLC or 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, LLC. 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, LLC **$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, LLC sole responsibility is to provide a receipt or "superbill" for us to file with the insurance company. I/We also understand that the fee stated above is payable to Joseph L. Nines, LLC on the day and time of services provided.

Any clinical information will be kept confidentially on file in paper records and/or electronically 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, LLC.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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FOR MEDICARE PATIENTS ONLY

Medicare ID#: _____-_____-_____

Medicare Supplemental Insurance Company: _____

Medicare Supplemental Insurance ID#: _____

In exchange for professional services, Joseph L. Nines, LLC will bill Medicare and my Supplemental Insurance Company directly. It is my/our responsibility to make sure that I/We qualify for coverage. If the insurance company denies Joseph L. Nines payment, I/We agree to pay a fee of **$125.00** for each session. I/We also understand that I/we are financially responsible for any co-payment, coinsurance, deductible or other fees incurred that are not covered by Medicare or my Supplemental Insurance Company

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____