**JMJ HEALTHCARE SERVICES, LLC**

**OUTPATIENT MENTAL HEALTH AND DIABETES CLINIC: CONSENT TO TREATMENT AND POLICIES**

**Payment Is Due At Time Of Service:** All co-pays, coinsurance or deductibles must be paid at the time of service. Balances owed from previous visits are expected to be paid in full at the time of your appointment. If a parent or another party takes responsibility for payment, the patient is still required to bring that payment to the appointment. **ALSO FOR DIABETES CARE SERVICES WE DON’T ACCEPT INSURANCE** **We accept Cash, Checks, Money Orders and Credit Cards THEIR WILL BE A $3 TRANSACTION FEE ON ALL CREDIT CARD TRANSACTIONS.**  **Initials\_\_\_\_**

**Cancellation Requires 24 Hour Advance Notice: When an appointment is scheduled, that time is reserved for you. A $60 fee will be charged for failure to cancel within this time frame.** Our answering machine is available to relay cancellations when the Office is closed. Emergencies may be excluded from this charge at the discretion of the Office Manager. **The $60 fee is also charged for No-Shows (not appearing for a scheduled appointment).** **NO EXCEPTIONS. Initials\_\_\_\_**

**Emergency Calls:** If you are calling weekdays after 7PM or on the weekend, you will reach our answering machine. If you are experiencing an emergency where seconds count, contact your local emergency room, crisis intervention, or 911. If your call is not an emergency, please leave one message including your name, numbers, and your reason for calling and someone will return your call the next business day. If you want your therapist/doctor to know that you are running late or unable to attend an appointment scheduled for that evening, please leave a message and our staff will periodically check our answering machine and notify your therapist/doctor as soon as possible. **Initials\_\_\_\_**

**Mandatory Check-Out at The Front Window:** All Patients are required to check out at the front window, to schedule an appointment for follow-up visits with Drs. Nwulia/Ebob/JaneFrances/Therapist. We realize this may result in having a line at the front window and will make every effort to minimize your wait time. We ask that you wait patiently and be respectful of the confidentiality of others in line. **Initials\_\_\_\_**

**Insurance Benefits and Billing:** Health insurance is a contract between you and your insurance company. For those companies with which we participate, we will file claims as a courtesy to our patients. However, *we cannot bill your insurance unless you provide a copy of your card and have completed the Patient Registration form and the insurance section.* We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, coinsurance, covered charges, secondary insurance, “usual & customary” charges, etc., other than to supply factual information as necessary. If you choose to use your insurance benefits **YOU** **are responsible for calling your insurance company to obtain co-pay, deductible, and benefit information.** If you have an overpayment on your account, it will credited to your account for further visits. It is your responsibility to be aware of your plan’s annual visit limits, deductible amounts, percentage of charges your insurance will pay, and non-covered services. JMJ bills neither secondary insurance nor those companies with whom we do not participate with. If requested, you will be provided with an invoice for services that contain all information necessary for you to bill your claims. **Initials\_\_\_\_**

**Minor Patients:** In the case of divorced or separated parents, the person accompanying the child/children is responsible for payment at the time of service. If there is a court order in effect and payment is not made in advance by the party responsible per the court order, payment must be made at the time of service by the adult accompanying the minor and reimbursement will be the responsibility of the parties involved. **Initials\_\_\_\_**

**Lost or Misplaced Prescriptions:** Due to increasing administration cost, there will be a $20 fee for lost or misplaced prescriptions as well as prescription requests when you don’t have an appointment with Dr. Nwulia/JaneFrances. **NO EXCEPTIONS. Initials\_\_\_\_**

**Medical Records, Letters and Completion of forms:** JMJ charges a fee for medical records, letters and completion of forms which varies from $25 to $200 based on complexity. Please allow one week from the date the request was made for the information to be available. **Initials\_\_\_\_**

**Termination of the Physician/Client Relationship:** If you have **NOT** been treated by Drs. Nwulia/ Ebob/JaneFrances/Therapist for 3 months or longer, you are no longer considered a patient, therefore no request for forms, documents or prescriptions will be honored. You must seek another psychiatrist by calling your insurance company to obtain further treatment. If you miss two (2) consecutive appointments, **you will be discharged from JMJ.** **Initials\_\_\_\_**

**I CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH AND DIABETES CARE AT JMJ HEALTHCARE SERVICES, LLC. INCLUDING PSYCHIATRIC EVALUATION, INDIVIDUAL, GROUP, FAMILY COUNSELING AS WELL AS MEDICATION MANAGEMENT AND DIABETES EDUCATION AND MEDICATION MANAGEMENT.**

This is to certify that I have read and understand this document.

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Signature of Responsible Party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

**JMJ HealthCare Services, LLC 3327 Superior Lane Suite 206 Bowie, Md. 20715**

***THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND DIABETES CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.***

**To Our Clients**: We know that protecting your privacy rights is important. Therefore, JMJ HealthCare Services, LLC is dedicated to maintaining the privacy of your personal mental health information as part of providing professional care. We also are required by law to keep your information private.

We believe that you should know how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. Here are a few examples of what we have in place to protect your right to privacy and confidentiality:

1. Our clinical and administrative staffs sign confidentiality statements. This affirms their commitment to protect your information.

2. We will use the information we collect about your mental health to provide you with **treatment**, to arrange **payment** for our services, and for other health care operations. After you have read this notice we will ask you to sign a **Consent for Treatment Form** to let us use and share your information. **If you do not consent and sign** **this form, we cannot treat you**.

3. If we or you want to use or disclose (send, share, release) your information, we will discuss this with you and ask you to sign a **Consent to Release Information Form.**

4. Of course we will keep your mental health information private, but there are times when the laws require us to use or share it. Here are a few examples:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

**Your rights regarding your mental health information:**

1. You can ask us to communicate with you about your mental health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care, such as family members and friends, or the payment for your care. While we don’t have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the mental health information we have about you such as your medical and billing records. Contact our Program Director to arrange to see your records.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your mental health information.
5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy from the Program Director
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Program Director and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the mental health care we provide to you in any way.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Program Director telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may have already have used or shared some of your information and cannot change that.

I **have received and understand the above notice concerning how my mental health and diabetes careinformation may be used and disclosed and how I can get access tothis information.**

**Signature of client or his/her guardian or personal representative Date**

**Relationship to client**

**JMJ HealthCare Services, LLC**

**CONSENT FOR TREATMENT**

Client’s Name: DOB:

JMJ HealthCare Services, LLC (JMJ) is an outpatient mental health and diabetes clinic. We provide individual, family and group counseling, and medication management.

**Treatment Agreement:**

I agree to participate with and through JMJ HealthCare Services, LLC, and I understand that this treatment will be for me/my child’s mental health and physical welfare. I understand that I have the right to have any medication or prescription recommendations explained to me in full and that I have the right to review medication or prescription recommendations explained to me in full and that I have the right to review medications with my psychiatrist or nurse representative.

I understand that I have the right to ethical and fair treatment given without regard to my race, religion, ethnic origin, sexual orientation or color. I understand that I have the right to appeal any decision made in my/my child’s treatment by first discussing it with my primary treating professional. I understand that if I am not satisfied with the determination of this appeal I may then appeal to the Program Director. I understand that I may refuse treatment within 48 hours’ notice. I understand that if I choose to refuse treatment or to rescind this agreement for treatment with JMJ, against medical advice, I will hold JMJ blameless and harmless for any pain or suffering I/ my child may incur as a result of that refusal or cessation of treatment. I have been given a copy of Patient Rights Policy, Grievance Process and Discharge Policy for my review.

*I understand that JMJ will receive compensation for the use or release of my mental health information.*

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Client/Parent/Guardian signature Relationship to Client Date

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JMJ LLC Staff Signature Date

**JMJ HealthCare Services, LLC**

**RELEASE OF INFORMATION**

Consumer’s Name: DOB:

**The confidentiality of Patients’ records maintained by JMJ HealthCare Services, LLC is protected by Federal Law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as a mental health or drug and alcohol substance abusing patient unless:**

**1. The patient consents in writing.**

**2. The disclosure is allowed by a court order; or**

**3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.**

**Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.**

**Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for JMJ or about any threat to commit such a crime.**

**I have received and understand the above notice concerning my confidentiality rights at JMJ. I have also received a copy of this notice.**

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Client/Parent/Guardian signature Relationship to Client Date

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JMJ Staff Signature Date

**JMJ HealthCare Services, LLC**

**Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:**

**PATIENT’S RIGHTS POLICY**

1. You have the right to receive appropriate humane treatment that restricts your personal liberty only to the extent necessary to your treatment or rehabilitation needs and applicable legal requirements.
2. You have the right to be protected from harm and to be free from mental, Physical and sexual abuse at the facility. All allegations of patient or client abuse by staff members must be reported to the local law enforcement agency.
3. You have the right to an individualized treatment or rehabilitation plan.
4. You have the right to participate, in a manner appropriate to your condition, in the development and periodic review of your treatment or rehabilitation plan.
5. You have the right to receive treatment or re habilitation as stated in your individualized treatment or rehabilitation plan.
6. You have the right to be told in appropriate terms and language of :

a) The contents and objectives of treatment or rehabilitation;

b) The nature and significant possible negative effects of treatment or rehabilitation;

c) The name, title and role of staff members who are directly responsible for carrying out your treatments or rehabilitation, and when appropriate;

d) Other treatments, services or providers of mental health services.

7. You have the right to have access to your treatment records and the right, with written permission, for your attorney to have access to your records. In the event your physician believes that it would be harmful to you to read your record, you have the right to a written summary of those sections of the record, which the physician believes might be harmful.

8. You have the right to refuse medication.

9. You have the right to refuse to participate in physically intrusive research.

10. You have the right, prior to admission, to an explanation in terms and language that you can understand of the admission and discharge policies.

11. You have the right, prior to admission to an explanation of your rights in terms and language that you can understand and to have a list of your rights posted in a prominent place in the facility.

12. You have the right, prior to admission, to an explanation, in terms and language that you can understand, of any charges and fees that you will be required to pay.

13. You have the right to an aftercare plan.

14. You have the right to privacy in our offices. Clients should be able to talk to their treatment coordinator in private and know that the information they supply will not be given out without their permission in writing. Any observers to the treatment will be identified and present only with the client’s permission. All records are confidential and protected by federal law and regulations. Federal Law and Regulations does not protect any information about a crime committed by a client, either at the program or against any person who works for the program. Federal law and Regulations does not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or Local Authorities (SEE §42 u.s.c.290dd-3 and 29cee-3 for Federal Laws and §42 CFR Part 2 for Federal Regulations).

15. You have the right to file a grievance if you are not satisfied with the treatment or rehabilitation that you receive.

**GRIEVANCE PROCESS**

1. In the event you have a grievance, you may personally, through or in combination with other persons, present grievances and recommend changes in policies and services on behalf of yourself or others without fear of reprisal, interference, coercion or discrimination.
2. A grievance may be initiated verbally, and must be confirmed in writing to the Program Director.
3. The grievance will be forwarded by the Director for review to the supervisor of a service area, a senior clinician, or an ad hoc committee.
4. The Director will review the report of the supervisor, clinician and or ad hoc committee and report in writing to the advisory board.
5. All of the above steps will be completed within 14 working days.
6. If appropriate, the written response will include an assessment of any factors contributing to the grievance, and proposed remedies, if any, to prevent a recurrence of problems.

**DISCHARGE POLICY**

An Individual Treatment Plan (ITP) will be developed by the client and the treatment coordinator. The ITP outlines long and short-term goals designed to address issues bringing the client to treatment. When these goals have been successfully attained or there is evidence of successful progress to attainment, the treatment coordinator and client will negotiate a plan of discharge with a clear date of termination. If alternative treatment is sought or a different choice of treatment is requested, the client will be discharged. The client may be readmitted at any time with a new intake process. The treatment coordinator will make referrals for necessary resources needed by the client after discharge and will document in the client’s record.

*I have been informed of and agree to my rights to medical care as stated above. I have been informed of and agree to the policies and procedures for submitting a grievance. I have been informed of and agree to the discharge policy for being discharged from JMJ, LLC. I understand the rights to medical care, policies and procedures, and the discharge policy as explained to me. If there is any portion of the rights, policies and procedures or the discharge policy which require further explanation, I understand that I am free to request explanation and assistance now or in the future.*

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Client/Parent/Guardian signature Relationship to Client Date

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JMJ Staff Signature Date

**Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Male \_\_\_ Female \_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Client: Parent Legal Guardian Self Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_**

**Is client covered under any other health insurance plan?  No  Yes, if so please provide us with your secondary insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral Source: (Name of Person): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Consumer’s Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\*Health alert (any known drug allergies or adverse reactions)***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Alternate Emergency Contact:***

***Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**I understand that in the event of any emergency, defined by staff, attempts will be made to contact any of the above for the purpose of notification. It is my preference that such treatment is provided by the above physician. I also freely give consent to JMJ to release to the above physician pertinent information relevant to such treatment.**

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Client/Parent/Guardian Signature Date

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JMJ Staff Signature Date

**JMJ HealthCare Services, LLC**

Client/Guardian:

It is very important that we provide the highest quality of service. Therefore, it is also very important that we maintain clear communication to prevent misunderstandings. Please carefully read the following information about our **cancellation/no show policy; our hours of operation and on-call emergency procedures:**

1. It is very important that you come to your appointments on a regular basis. Your (or your child’s) sessions are reserved for you. If you do not keep your appointments, progress in treatment will suffer. We would appreciate being notified within 24 hours of a cancellation.

2. We discharge clients after 2 consecutive “No Shows.”

3. The program operates Monday – Friday from 9:30 am to 7:00 pm. On-call and emergency services are provided through live “answering service.” A staff member is on on-call in the evenings and on the weekends by cell phone. The cell number can be accessed by calling the program’s main number @ 240-206-8345.

Emergency procedures are available 24/7. For immediate help in a crisis situation, **please call the Prince George’s County Crisis Response System @ 301-429-2185. In a life** threatening situation, 911 should be called immediately.

Please do not hesitate to talk to the Medical Director or your therapist about any problems or concerns you may be experiencing with the services provided. We will discuss your concerns with you with the hope that the issue can be resolved.

Thank you for choosing **JMJ HealthCare Services, LLC** as your provider and we look forward to working with you.

I have read and understand the above notice regarding the program’s cancellation/no show policy; hours of operation and on-call emergency procedures

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Signature of Client (or guardian) Date

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JMJ Staff Signature Date