

## CORNERSTONE CLINICAL SERVICES CONSENT FOR TREATMENT

Welcome to Cornerstone Clinical Services. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them during our meeting. Once you sign this, it will constitute a binding agreement between us.

### PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the training and personality of both the therapist and the client and the particular problems that the client brings. There are a number of different approaches that can be utilized to address the problems you hope to address. It is not like visiting a medical doctor, in that it requires a very active effort on your part. In order to be most successful, you will have to work both during our sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires recalling unpleasant aspects of your history. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, better relationships and resolution of specific problems, but there are no guarantees about what will happen.

The end of the evaluation will offer you some initial impressions of what our work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with the therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you to secure an appropriate consultation with another mental health professional.

### MEETINGS

Our normal practice is to conduct an evaluation that will last from 1 to 3 sessions. During this time, we can both decide whether the therapist is the best person to provide the services that you need in order to meet your treatment objectives. If psychotherapy is initiated, we will usually schedule one 45-50 minute session per week at a mutually agreed time, although sometimes sessions will be more or less frequent. **Once this appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (or unless we both agree that you were unable to attend due to circumstances which were beyond your control). Insurance companies will not pay for this fee.** If it is possible, we will try to find another time to reschedule the appointment. If you need to cancel your appointment when the office is closed, please leave a message with our 24-hour voice mail.

### PROFESSIONAL FEES AND LEGAL INVOLVEMENT

The hourly fee for psychologists is \$150 for individual therapy and \$180 for family therapy. The initial consultation fee is \$230. Please speak to your provider if you are here for psychiatric care in order to determine fees for the desired service. Write offs of part of this fee may be required depending on the contract with your insurance company. Subsidized cash fees may be available depending on annual income. In addition to weekly appointments, it is our practice to charge an hourly rate on a prorated basis for other professional services you may require, such as report writing, telephone conversations which last longer than 10 minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries or the time required to perform any other service which you may request. Insurance companies do not pay for these services in most cases.

In unusual circumstances, you may become involved in litigation that may require the therapist's participation. (If you expect that your care will require this involvement, then please speak to your individual Cornerstone therapist to determine whether it is within the scope of their practice.) It is important for you to know that we are not forensic psychologists and will not be a party to legal proceedings against current or former clients. The goal is to support progress towards treatment goals and entering treatment is an agreement to not involve your clinician in legal proceedings or to attempt to obtain records of treatment for legal proceedings when marital or family treatment has been unsuccessful at resolving conflict. In the rare cases in which court involvement is required, you will be expected to pay for the professional time required even if the clinician is compelled to testify by another party. You will also be expected to pay at least fifty percent of the anticipated fee for time spent in the form of a retainer. (Because of the complexity and difficulty of legal involvement, clinicians charge \$110 per hour for preparation and travel time and \$250 per hour for attendance at any legal proceeding.)

### **BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage that requires another arrangement. If you have insurance coverage, the business office will calculate your estimated copayment to be paid at the time of service. Payment schedules for other professional services will be agreed to at the time these services are requested. (In circumstances of unusual financial hardship, the therapist may be willing to negotiate a fee adjustment or installment payment plan.) We accept personal checks, money orders, cash, VISA, and Mastercard.

We will bill your insurance company. Clients will receive statements once a month showing activity for the month. The estimated client balance due listed on the client statement is payable upon receipt of the monthly statement.

The office does not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account, including any unpaid insurance claims.

If payment arrangements must be made, please contact the business office.

Client balances that are 60+ days past due will be assessed a 1-1/2% (18% annual) service charge.

Accounts carried 90 days without payment may be turned over to a collection agency. In that event, the contingency fee assessed by the collection agency will be added to the principal and service charges due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe. If your account is turned over to a collection agency, it may affect your credit rating. In most cases, the only information that is released to a collection agency about a client's treatment would be the client's name, the nature of the services provided, and the amount due.

### **INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health benefits policy, it will usually provide some coverage for mental health treatment. Our office will verify your insurance benefits as a courtesy to you. Verification of benefits quoted to our office is not a guarantee of payment. In addition, we will provide you with whatever assistance we can in facilitating your receiving the benefits to which you are entitled. However, you, and not your insurance company, are responsible for full payment of the fee that we have agreed to. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers.

The escalation of the cost of health care has resulted in an increasing level of complexity about insurance benefits that sometimes makes it difficult to determine exactly how much mental health coverage is available. "Managed Health Care Plans" such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. These plans are often oriented towards a short-term treatment

approach designed to resolve specific problems that are interfering with one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions.

You should also be aware that insurance agreements require you to authorize us to provide a clinical diagnosis, and, depending on the insurance carrier, many require additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, we have no control over what they do with it. In some cases they may share the information with a national medical information data bank. If you request it, we will provide you with a copy of any report that we submit.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if the insurance benefits run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for our services yourself and avoid the complexities that are described above.

### **CONTACTING THE THERAPIST**

We are often not immediately available by telephone. While we are usually in our offices between normal business hours, we are not able to answer the phone when we are with a client. Our telephones are answered by a secretary who usually knows where to reach us. If you are difficult to reach, please leave some times when you will be available. In case of after-hour emergencies, the office voice mail will provide directions on how to contact an on-call therapist. If for some reason these services do not appear to be adequate, you should call your family physician, the mental health crisis line for your county of residence or the emergency room at the nearest hospital.

### **PROFESSIONAL RECORDS**

As you are probably aware, we are required to keep appropriate records of our work together. You are entitled to receive a copy of the record unless we believe that seeing it would be emotionally damaging, in which case we will be happy to forward the record to an appropriate mental health professional of your choice. In general, because professional records can be subject to misinterpretation, we recommend that if you are to request your record we review it together so that we can discuss any questions that may arise. You should be aware that this will be treated in the same manner as any other professional (clinical) service and you will be billed accordingly.

### **MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is our policy to request an agreement from parents that they will not ask what you are specifically saying in therapy. If they agree, we will provide them only with general information on how your treatment is proceeding unless we feel that there is a high risk that you will seriously harm yourself or another, in which case we will notify them of our concern. We will also be available to answer general questions or provide family sessions.

Parents of minor clients hold the legal right of privilege or confidentiality. A non-custodial parent who wants to learn about their child's treatment may have the right to review the child's record and to discuss their child's care with your clinician. However, it is our experience that therapy can be greatly hindered if teens feel the therapist is simply a conduit to their parents and many are reluctant to discuss personal issues without privacy. Therefore, the office has the following policy:

Parents are given general information about therapeutic progress. Regular consults are encouraged (every 2-3 sessions) unless contraindicated. Teens are informed of phone calls or contact between sessions. When parents are consulted, minors are given the option to remain or leave the room. For difficult issues, family sessions are encouraged with the therapist assisting the minor and the parents in working towards a resolution.

The therapist will notify parents if the minor is in danger of hurting him/herself, someone else, or is a victim/perpetrator of child abuse. Parents are encouraged to discuss any concerns with the therapist in front of the child if appropriate to age and developmental level.

Please note that in the situation of custody disputes, it is not appropriate for a treating therapist to make comment or recommendations on custody issues. If we are treating your child, it is our policy to not speak to either parent's legal counsel in regards to family law issues, but may answer the questions of the appointed custodial evaluator. If consultation with your attorney is desired, please inform your therapist at intake so that an appropriate referral to a forensic psychologist can be made.

### **WORKING WITH COUPLES**

In counseling where the couple is present together, personal, confidential information on each person is recorded and contained in the same clinical file. When and if there is a need for one person to access information on self or other from that file, we will protect each person's privacy by requiring written consent to release that information from each of you before we would release that information to either or both of you, or to any other authority or agency.

### **CONFIDENTIALITY**

In general, law protects the confidentiality of all communications between a client and a psychologist, and we can only release information about our work to others with your written permission. However, there are a number of exceptions:

If we are subpoenaed to testify in court, we may have to give information about you without your permission. If we are subpoenaed we will make an effort to contact you. If you oppose release of information, a court may nevertheless require compliance with the subpoena. In some circumstances a judge may require our testimony, even though we have claimed privilege on your behalf, if he or she determines that resolution of the issues demands it. If you claim an emotional condition in a civil or criminal court proceeding, this also removes confidentiality.

There are some situations in which we are legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment:

If we believe that a child, an elderly person, or a disabled person is being abused, we may file a report with the appropriate state agency.

Clients should be aware that all Clinical Social Workers and Master Level Counselors are legally required to report all instances of child, disabled, and elder abuse reported to them. Though Psychologists are not legally mandated to make a report of abuse when reported within the therapy relationship, many make it their personal policy to do so. Questions regarding reporting requirements or legal definitions of abuse should be directed to your therapist.

If we believe that a client is threatening serious bodily harm to another, we may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, we may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

These situations have rarely arisen in our practice. Should such a situation occur, we would make every effort to fully discuss it with you before taking any action.

We may occasionally find it helpful to consult about a case with other professionals. If you are seeing more than one clinician at Cornerstone, those clinicians will attempt to coordinate your care through case review without requesting your written permission. Please understand that this will be standard of care unless you choose to place a restriction upon the sharing of information.

If we need to consult with a professional outside of Cornerstone, we will request your permission or make every effort to avoid revealing any identifiable information. Unless you object, we will not tell you about these consultations unless we feel that it is important to our work together.

This practice reviews cases for quality assurance. A utilization review/quality assurance group set up by your insurance company or members of this practice may review your case.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. As you might suspect, the laws governing these issues are quite complex and we are not attorneys. While we are happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, we will provide you with relevant portions or summaries of the applicable state laws governing these issues.

**GRIEVANCES**

If you have a grievance regarding any services received at Cornerstone Clinical Services, please note your right to explore these concerns with your specific clinician, the owners of the corporation, your specific health insurance company or the Oregon State licensing board for the discipline of your provider.

A copy of this document will be provided upon your request.

Your signature(s) below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

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Client's Name

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Client's Signature  
(Parent or Guardian if under 18)

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Spouse's Signature

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Date

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Date

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

*If you have questions about this notice, please contact the privacy officer at  
Cornerstone Clinical Services, P.C.  
6400 SE Lake Road, Suite 325, Milwaukie, OR 97222*

## **WHO WILL FOLLOW THIS NOTICE**

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

## **YOUR HEALTH INFORMATION**

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

## **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose health information for the following purposes:

**For Treatment.** We may use health information about you to provide you with clinical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your clinical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your clinical care outside this office and may require information about you that we have.

**For Payment.** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for treatment.

**For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

**Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment or clinical care at the office.

**Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Products and Services.** We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

## **SPECIAL SITUATIONS**

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

**To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required by Law.** We will disclose health information about you when required to do so by federal, state or local law.

**Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

**Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

**Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

## **OTHER USES AND DISCLOSURES OF HEALTH INFORMATION**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization, in writing*, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information.

## **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as clinical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Cornerstone Clinical Services, P.C. in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies.

We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

**Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a CLINICAL RECORD AMENDMENT/CORRECTION FORM to Cornerstone Clinical Services, P.C.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of clinical information about you for purposes other than treatment, payment, health care

operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

To obtain this list, you must submit your request **in writing** to Cornerstone Clinical Services, P.C. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example: on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

*We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION to Cornerstone Clinical Services, P.C.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to Cornerstone Clinical Services, P.C. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

To obtain such a copy, contact Cornerstone Clinical Services, P.C.

## **CHANGES TO THIS NOTICE**

We reserve the right to change this notice, and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the privacy officer at Cornerstone Clinical Services, P.C. *You will not be penalized for filing a complaint.*

# ACKNOWLEDGMENT AND CONSENT

I understand that Cornerstone Clinical Services, P.C. will use and disclose health information about me. I understand that my health information may include information both created and received by the practice/facility, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Cornerstone Clinical Services, P.C. may use and disclose my health information in order to:

- ❖ Make decisions about and plan for my care and treatment;
- ❖ Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- ❖ Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- ❖ Perform various office, administrative, and business functions that support my practitioner/provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Cornerstone Clinical Services, P.C. will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of Cornerstone Clinical Services, P.C., and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Cornerstone Clinical Services' Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices and I understand that Cornerstone Clinical Services, P.C. is not required by law to agree to such requests.

**By signing below, I agree that I have received and understand the information above and that I have received a copy of the Notice of Privacy Practices.**

By: _____	Date: _____
(Patient)	

-- OR --

By: _____	Date: _____
(Patient's Representative)	
Description of Representative's Authority: _____	

# Cornerstone Clinical Services, P.C.

Please complete ALL sections

Clinician: \_\_\_\_\_

## Patient Registration Form

Patient's full name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ M/F Marital M S D W  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_ Employer \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
May we leave messages for you at home? Yes \_\_\_\_\_ No \_\_\_\_\_ May we leave messages at work? Yes \_\_\_\_\_ No \_\_\_\_\_

### Person Responsible for Account (if other than above)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ SS # \_\_\_\_\_  
Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_ Driver's License \_\_\_\_\_

*If you would like our office to bill your insurance company, the following information will be required*

### Primary Insurance

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ Group \_\_\_\_\_ SS # \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Address \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

### Secondary Insurance

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ Group \_\_\_\_\_ SS # \_\_\_\_\_  
Employer \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

### Assignment of Insurance Benefits and Agreement to Pay

I have completed the above to the best of my knowledge. If the information changes, I will notify Cornerstone Clinical Services. They are not liable for incorrect information. Cornerstone Clinical Services has my permission to bill my insurance company(ies). I authorize the release of any medical information necessary to process these claims. I authorize medical benefits to be paid to Cornerstone Clinical Services or to the clinician rendering services.

\_\_\_\_\_  
INSURED SIGNATURE

\_\_\_\_\_  
DATE

(Continued on reverse)

## Billing Policies

Payment is required at the time of service. If you have insurance coverage, the business office will calculate your estimated co-insurance to be paid at the time of service.

We accept personal checks, money orders, cash, VISA, and MasterCard.

We will bill your insurance. You will be billed for unpaid balances after your insurance processes. The office does not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account, including any unpaid insurance claims.

If payment arrangements must be made, please contact the business office.

Client balances that are 60+ days past due will be assessed a 1-1/2% per month (18% annual) service charge.

Accounts carried 90 days without payment may be turned over to a collection agency. In that event, the contingency fee assessed by the collection agency will be added to the principal and service charges due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe. If your account is turned over to a collection agency, it may affect your credit rating. In most cases, the only information that is released to a collection agency about a client's treatment would be the client's name, the nature of the services provided, and the amount due.

We require a 24-hour notice for cancellations. If a 24-hour notice is not given, a late cancellation or no show charge of \$75 (minimum) will be assessed. Insurance companies will not be billed for this fee; it is the client's responsibility. In case of illness, please contact the office as soon as possible to cancel your appointment. If you need to cancel your appointment when the office is closed, please leave a message on our voice mail.

Please sign below indicating your understanding of the information above. If you wish, the office will provide you with a copy of this policy.

---

*Signature of Responsible Party*

---

*Date*

# Adult Information Form

Client name: \_\_\_\_\_

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Ok to leave message?  YES  NO  
Work Phone: ( ) \_\_\_\_\_ Ok to leave message?  YES  NO  
Current Employer (or school if a student): \_\_\_\_\_  
Gender: Male  Female  Who referred you to Cornerstone: \_\_\_\_\_

WHO MAY WE CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_  
Daytime Phone: ( ) \_\_\_\_\_ Evening Phone: ( ) \_\_\_\_\_  
Spouse's Name (if applicable): \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

### Current Marital Status

Single (duration: \_\_\_\_\_)  Married (duration: \_\_\_\_\_)  
 Unmarried, living together (duration: \_\_\_\_\_)  Separated (duration: \_\_\_\_\_)  
 Divorcing (duration: \_\_\_\_\_)  Divorced (duration: \_\_\_\_\_)  
 Widowed (duration: \_\_\_\_\_)

### Education

Currently in school:  YES  NO Total years of education: \_\_\_\_\_  
 High School Graduate  
 G.E.D. Major area(s) of study/training \_\_\_\_\_  
 Vocational: # of years \_\_\_\_\_ Graduated:  YES  NO \_\_\_\_\_  
 College: # of years \_\_\_\_\_ Graduated:  YES  NO \_\_\_\_\_  
 Graduate School: # of years \_\_\_\_\_ Graduated:  YES  NO \_\_\_\_\_  
Special Services? (special education, learning disabilities, etc) \_\_\_\_\_

### Employment

Are you currently employed:  YES  NO  
Current Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_  
Length of time employed: \_\_\_\_\_ Job responsibilities: \_\_\_\_\_  
Level of stress of job: \_\_\_\_\_ Other jobs you have worked: \_\_\_\_\_

### Legal

Are you involved in any legal activities (civil, criminal, custody, probation/parole, etc)?  YES  NO  
If yes, please describe: \_\_\_\_\_  
Past History:  
Traffic Violations:  YES  NO DUII/DWI, etc.:  YES  NO  
Felony/Misdemeanor charges?  YES  NO Civil/custody lawsuits:  YES  NO

### Military Experience

Military experience?  YES  NO (if no, skip this section)  
Branch of Service: \_\_\_\_\_ Date enlisted/drafted: \_\_\_\_\_  
Discharge date: \_\_\_\_\_ Type of discharge: \_\_\_\_\_ Rank at discharge: \_\_\_\_\_  
Combat experience?:  YES  NO Other stressors experienced: \_\_\_\_\_

Therapist Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Adult Information Form

Client name: \_\_\_\_\_

## PRESENTING PROBLEMS/CONCERNS

Describe the problem that brought you here today: \_\_\_\_\_

What do you hope to gain from therapy: \_\_\_\_\_

Please check behaviors and symptoms that occur to you more often than you would like:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Aggression/fighting | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Sleeping problems     |
| <input type="checkbox"/> Alcohol abuse       | <input type="checkbox"/> Drug abuse          | <input type="checkbox"/> Judgment errors     | <input type="checkbox"/> Speech problems       |
| <input type="checkbox"/> Angry outbursts     | <input type="checkbox"/> Eating disorder     | <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Suicidal thoughts     |
| <input type="checkbox"/> Arguments/conflicts | <input type="checkbox"/> Elevated mood       | <input type="checkbox"/> Memory impairment   | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Mood swings         | <input type="checkbox"/> Trembling             |
| <input type="checkbox"/> Avoiding people     | <input type="checkbox"/> Gambling            | <input type="checkbox"/> Panic attacks       | <input type="checkbox"/> Withdrawing           |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Hallucinations      | <input type="checkbox"/> Phobias/fears       | <input type="checkbox"/> Worrying              |
| <input type="checkbox"/> Computer addiction  | <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Recurring thoughts  | <input type="checkbox"/> Other (specify)       |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sexual addiction    | _____  |
| <input type="checkbox"/> Disorientation      | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Sexual difficulties | _____  |
| <input type="checkbox"/> Distractibility     | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Frequent illness    | _____  |

Briefly describe how the above checked symptoms impair your ability to function effectively: \_\_\_\_\_

Have you ever had thoughts or made statements of wanting to hurt yourself or seriously hurt someone else?  YES  NO. If YES, please describe the situation: \_\_\_\_\_

Have you ever purposely hurt yourself or another?  YES  NO. If YES, please describe the situation: \_\_\_\_\_

## PRIOR MENTAL HEALTH TREATMENT

Type of Treatment	No	Yes	Start/End Dates	Provider name/ primary reason for treatment
Counseling or Psychiatric Care:				
Drug/Alcohol Treatment:				
Psychiatric Hospitalization:				
Medication for mental health problem:				
Self-help/support group:				

Therapist Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Adult Information Form

Client name: \_\_\_\_\_

## FAMILY & DEVELOPMENTAL HISTORY

Relationship	Name	Age	Deceased?	Quality of relationship	Family mental health problems?	Who?
Mother:					Depression	
Father:					Anxiety	
Stepmother:					Sexual abuse	
Stepfather:					Attention deficit	
Spouse/partner:					Alcohol abuse	
Children:					Drug abuse	
					Schizophrenia	
					Manic-Depression	
Siblings:					Imprisonment	
					Suicide	
					Eating disorders	
					Panic attacks	
					Obsessive/compulsive	

**Parental Marital Information:**

- |  |  |
|--|--|
| <input type="checkbox"/> Parents legally married     | <input type="checkbox"/> Mother remarried: Number of times _____ |
| <input type="checkbox"/> Parents have been separated | <input type="checkbox"/> Father remarried: Number of times _____ |
| <input type="checkbox"/> Parents divorced            |  |

Is there anything happening NOW in your current living situation or in your family that is especially stressful for you?

\_\_\_\_\_

\_\_\_\_\_

Please check if you have suffered any of the following types of trauma:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Neglect               | <input type="checkbox"/> Emotional abuse               | <input type="checkbox"/> Physical abuse       |
| <input type="checkbox"/> Sexual abuse          | <input type="checkbox"/> Loss of loved one             | <input type="checkbox"/> Natural disaster     |
| <input type="checkbox"/> Teenage pregnancy     | <input type="checkbox"/> Parental substance abuse      | <input type="checkbox"/> Crime victim         |
| <input type="checkbox"/> Violence in the home  | <input type="checkbox"/> Parents separated or divorced | <input type="checkbox"/> Financial problems   |
| <input type="checkbox"/> Parental illness      | <input type="checkbox"/> Homelessness                  | <input type="checkbox"/> Lived in foster home |
| <input type="checkbox"/> Multiple family moves | <input type="checkbox"/> Other: _____                  |   |

Please comment on any of the above checked items (including your age when the trauma occurred and the details of the traumatic event): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Therapist Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Adult Information Form

Client name: \_\_\_\_\_

## CHEMICAL USE HISTORY

Substance Type	Current Use (within the last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
PCP/LSD								
Heroin/opiates								
Methamphetamines								
Inhalants								
Other:								

Have you had withdrawal symptoms when trying to stop using any substances?  YES  NO. If YES, please describe the situation: \_\_\_\_\_

Have any substances created a problem for you at work or home?  YES  NO. If YES, please describe the situation: \_\_\_\_\_

Therapist Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## SOCIAL/CULTURAL HISTORY

Please check how you generally get along with other people: (check all that apply)

- Affectionate   
  Aggressive   
  Avoidant   
  Fight/argue often   
  Follower   
  Assertive  
 Friendly   
  Leader   
  Outgoing   
  Shy/withdrawn   
  Submissive

Describe special areas of interest or hobbies (i.e. art, books, crafts, physical fitness, etc.)

Activity	How often now?	How often in the past?

Please describe your strengths, skills and talents: \_\_\_\_\_  
 \_\_\_\_\_

To which cultural or ethnic group do you belong? \_\_\_\_\_

Are you experiencing any difficulties due to cultural or ethnic issues? If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Therapist Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# Adult Information Form

Client name: \_\_\_\_\_

How important are spiritual matters to you?  Not at all  Little  Somewhat  Very much

Are you affiliated with a particular spiritual or religious group?  YES  NO

If yes, please describe: \_\_\_\_\_

Would you like your spiritual/religious beliefs incorporated into the counseling?  YES  NO

## MEDICAL INFORMATION

Current Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

When was your most recent complete physical examination? \_\_\_\_\_

Have you suffered from any of the following medical conditions during your lifetime?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> A serious accident | <input type="checkbox"/> Surgery             | <input type="checkbox"/> Allergies                      |
| <input type="checkbox"/> A head injury      | <input type="checkbox"/> Meningitis          | <input type="checkbox"/> Hospitalizations               |
| <input type="checkbox"/> High fevers        | <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Headaches                      |
| <input type="checkbox"/> Vision problems    | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Loss of consciousness          |
| <input type="checkbox"/> Ear infections     | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pregnancy/miscarriage          |
| <input type="checkbox"/> Stomach aches      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Speech/language problems       |
| <input type="checkbox"/> Abortion           | <input type="checkbox"/> Chronic pain        | <input type="checkbox"/> A sexually transmitted disease |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Thyroid problems               |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Other: _____        | <input type="checkbox"/> Other: _____                   |

Please describe any checked items noting your age at the time of onset: \_\_\_\_\_

List any current health concerns: \_\_\_\_\_

Current medications:  None

<u>Medication</u>	<u>Dosage</u>	<u>Date First Prescribed</u>	<u>Prescribed By</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter medications\*:  None (\*includes vitamins, herbal remedies, etc.) \_\_\_\_\_

Allergies and/or adverse reactions to medications:  None (If yes, please list): \_\_\_\_\_

Therapist Notes: _____ _____ _____ _____ _____
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