Cornerstone Wellness Center

NEW PATIENT - CHILD:

Who is the appointment with today?_____ **Appointment date:**_____

Child's Name:_____
Last First Middle Initial

Child's Date of Birth:_____ **Gender (circle): M / F**

Name of Legal Guardian/Parent:_____
Last First Middle Initial

Address:_____
Street City State Zip

Phone:_____
Home Legal Guardian/Parent Work Cell

Which phone number is okay to leave messages?_____

Legal Guardian/Parent Date of Birth:_____ **Employer:**_____

Family Doctor: _____ **May we contact your doctor? Y / N (If yes, please sign Release of Information in packet)**

Referred By:_____ **Known allergies:**_____

Emergency Contact & Relationship:_____ **Phone:**_____

Child's School:_____ **Grade:**_____ **Classroom teacher:**_____

Legal Guardian/Parent marital status (circle): single married divorced separated widow

Partner's name:_____

Please explain custody arrangements and provide copy of custody agreement and visitation (If Applicable):_____

_____

Name of other parent:_____
Last First Middle Initial

Address:_____
Street City State Zip

Phone:_____
Home Office Ext. Cell

Date of Birth:_____

PLEASE SEE NEXT PAGE

Cornerstone Wellness Center

Child's name:_____

The following must be signed by the parent or legal guardian:

I authorize payment of Medical Benefits to Cornerstone Wellness Center, L.L.C. for any services.

_____ _____
Signature **Date**

I authorize the release of information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payors, including Employee Assistance Programs (EAP). I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf unless disallowed by my insurance company. I understand that if I do not render such payment, Cornerstone Wellness Center, L.L.C. reserves the right to attempt to collect said payment, up to and including using the services of a collection agency. Accounts referred to an outside collection agency are subject to a fee of 35% of the total amount due.

_____ _____
Signature **Date**

Cardholder's Information: This section needs to have the insurance cardholder's information so that we can file claims for you.

Name:_____ **Date of Birth:**_____
Last First MI

Relationship to Child:_____ **Social Security #:**_____

Address:_____
Street City State Zip

Phone:_____
Home Office Ext. Cell

Name of Insurance Company:_____

ID Number:_____ **Group Number:**_____

Name of Second Insurance Company (If Applicable):_____

ID Number:_____ **Group Number:**_____

Employment: (Circle one): Full-time Part-time Unemployed

Full-time Student Part-time Student

Employed at:_____

Cornerstone Wellness Center

Welcome to Cornerstone Wellness Center. **This document is meant to clarify our therapeutic relationship, and contains important information about my professional services and business policies. I am committed to serving you with caring and compassion. I sincerely thank you for the opportunity to serve you.**

Psychological Services

Psychological services have both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration. Therapy often requires discussing unpleasant aspects of your life. However, therapy has been shown to have benefits for people who undertake it, such as leading to an overall improvement in your well being, better relationships, and solutions of specific problems. Therapy requires a very active effort on your part. In order to be most successful you will have to work on things we talk about at our sessions at home. It is important to understand that there is no guarantee of the success of services.

Sessions

My usual practice is to conduct an evaluation, which will last from one to four sessions. During this time we can both decide whether I am the best person to provide the service which you need in order to meet your treatment objectives. If therapy is initiated I will usually schedule one 50-minute session per week at a mutually agreed time although sometimes the sessions' length and frequency may vary. You have chosen to receive treatment services; your choice has been voluntary and you understand that you may terminate therapy at any time.

The initial visit fee is $225. My fee after that for one therapeutic hour (38-52 minutes) is $140. It is my practice to charge this amount on a prorated basis for sessions lasting more or less than one therapeutic hour. For example the fee for a 16-37 minute session is $80, and a 53 or more minute session is $175. Charges for testing may be different.

Phone Calls

I will make every effort to return phone calls as soon as possible, or have my office manager return your call. Phone calls with me during office hours lasting for more than 10 minutes will be charged at the above mentioned counseling rates. Emergency phone calls or phone calls in which you call me or require me to call you during non-office hours will be charged as follows: 10-30 minutes = $50.00, 30-45 minutes = $100.00, and 45-60 minutes = $150.00. Calls lasting longer than one hour will be prorated.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which allows another arrangement. Co-payments and deductibles are due at the time services are rendered. You will be sent statements for any unpaid balances when we receive claims information from your insurance company.

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You are responsible for knowing your own insurance benefits. I will provide you with whatever assistance I can in facilitating your receipt of the benefits to which you are entitled, including filling out forms as appropriate. However, you will be responsible for the remaining fee unpaid by your insurance company..

You should also be aware that many insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes a treatment plan or summary.

Cancellations

If you need to cancel or change your appointment time, please call us at least 24 business hours in advance to do so. Canceling within 24 business hours or not showing up for your appointment will result in a $50 fee billed to you, not your insurance company. It is up to the discretion of this office to discontinue scheduling patients who have too many last minute cancellations or fail to keep their appointments.

_____ __

(please initial)

Cornerstone Wellness Center

Client Rights and Informed Consent

- **I have chosen to receive treatment services and understand I may terminate therapy at any time, unless ordered by court.**
- **I understand there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.**
- **I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.**
- **I understand the records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.**
- **I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.**
- **I understand that state and local laws require my therapist report all cases in which there exists danger to self and others.**
- **I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.**
- **I understand that I may be contacted by my health plan to ensure continuity and quality of my treatment and /or after the completion of treatment, to assess the outcome of treatment.**
- **I have read and/or had explained to me this information pertaining to the basic rights of individuals who undergo treatment through psychotherapy. These rights include:**

    - **The right to be informed of the various steps and activities involved in receiving services.**
    - **The right to share in the formation of the plan of care/treatment plan.**
    - **The right to confidentiality under federal and state laws relating to the receipt of services.**
    - **The right to humane care and protection from harm, abuse, or neglect without regard to race, color, religion, gender, sexual orientation, age, disability, or cultural background.**
    - **The right to make an informed decision whether to accept or refuse treatment.**
    - **The right to contact and consult with counsel at my expense.**
    - **The right to select practitioners of my choice at my expense.**

I understand that my therapist, health plan representatives, and my primary care physician may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

_____ _____

Signature of Parent/Guardian/Conservator **Date**
Authorized Representative

_____

Print Child's Name

Cornerstone Wellness Center

Notice of Privacy Practices

This notice of Privacy Practices describes how we may use and disclose your *Protected Health Information* (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your PHI will be used, as needed, to obtain payment for your health care serves. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your PHI in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may call your name in the waiting room when your therapist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, health oversight, abuse or neglect; Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroner, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity, and National Security, Inmates, Workers' Compensation, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

PLEASE SEE NEXT PAGE TO SIGN

Cornerstone Wellness Center

Your Rights

Following is a statement of your rights with respect to your Protected Health Information.

- **You have the right to inspect and copy your PHI.**

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

- **You have the right to request a restriction of your PHI.**

This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must specify the restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If your therapist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You also have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.**

- **You may have the right to have your physician amend your PHI.**

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a compliant.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____ _____

Legal Guardian Signature **Date**

Cornerstone Wellness Center

Informed Consent for Treatment

I _____ am the legal guardian or custodial parent of

_____and I agree and consent to participate in behavioral health care services offered and provided at Cornerstone Wellness Center, LLC, a behavioral healthcare provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/ or legally authorized to initiate and consent to treatment on behalf of this individual.

_____

Signature of Parent/Legal Guardian **Date**