Client Information – Child Referred by: _____ Date: _____

Name: _____ Date of Birth: _____

Home Address: _____ Gender: _____

City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian: _____ Date of Birth: _____

Home Phone: (_____) -_____-_____ Cell Phone: (_____) -_____-_____

Work Phone: (_____) -_____-_____ Oth. Phone: (_____) -_____-_____

Which number is okay to leave messages? _____

Guardian's E-Mail Address: _____

Guardian's Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated

Custody arrangements (Provide a copy of custody agreement if applicable): _____

_____

Other Parent Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Doctor: _____ Known Allergies: _____

Insurance Information

Insurance Company: _____

Insured Person: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Insured's Street Address: _____

Insured's City: _____ State: _____ Zip:_____

Insured's Phone: (_____) - _____ - _____

Insured's Gender: ☐ M ☐ F Insured's Date of Birth: _____/_____/_____

Insured's ID # (from card): _____

Insured's Group # (from card): _____

Client Rights and Informed Consent for Treatment

1) I have chosen to receive treatment services and understand I may terminate therapy at any time, unless ordered by court.
2) 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.
3) I understand that during my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.
4) 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.
5) I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.
6) I understand that state and local laws require my therapist report all cases in which there exists danger to self and others.
7) I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
8) 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.
9) 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.
10) 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.
11) I agree and consent to participate in behavioral health care services offered and provided at Cornerstone Wellness Center, L.L.C., a behavioral health care 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. If the patient is unable to consent for treatment, 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.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____

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.

_____
initials

Financial Agreement and Attendance Policies
I authorize the release of information including the diagnosis and the records of any treatment of examination rendered to me during the period of such care to third party payers, including Employee Assistance Programs (EAP). I understand that CWC will help facilitate the receipt of insurance benefits to which I am entitled, but that ultimately, I am responsible for knowing my own benefits. I authorize and request my insurance company to pay Cornerstone Wellness Center directly. 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 behalf or my dependents 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.

_____
initials

Fees:

Initial Visit: $225.00	Family Visit: $140.00
38-52 min: $140.00	Psych Testing (each hr): $175.00
53-89 min: $175.00	Group Sessions: $140.00

I understand that failure to cancel a scheduled appointment within 24 hours may result in a $50.00 charge billed directly to me, not my insurance company. Not receiving a reminder call is not a valid reason to miss a scheduled appointment. Exceptions to this policy are at the discretion of CWC and with respect to contractual agreements with third party payers.

_____
initials

By my signature, I acknowledge my agreement to pay the above listed fees for service and acknowledge my responsibility to comply with the attendance policy for the duration of my enrollment at Cornerstone Wellness Center. I understand that payment in full is expected at the time of service.

Guardian Signature: _____ **Date**: _____

Acknowledgement of Privacy Practices Policy: I acknowledge that I am aware of Cornerstone Wellness Center's Notice of Privacy Practices. I understand that CWC has the right to revise and/or amend the NPP. I understand that if the NPP is revised, the revised notice will be posted at CWC and I have the right to obtain a current copy at any time.

Guardian Signature: _____ **Date**: _____

Cornerstone Wellness Center

Consent to Confidential Treatment for a Minor Child

I _____ , am the legal guardian or custodial parent of _____, who is about to engage in counseling or psychological assessment at Cornerstone Wellness Center. I understand that assessments and counseling may depend, in part, on the client disclosing information that he or she might not want to have repeated to others, including me.

I give my permission to the staff of Cornerstone Wellness Center to withhold the following information from me, if it comes out during the course of evaluation or treatment of the above named person (please initial):

_____ Violations of the Law
_____ Use of Alcohol
_____ Use of Other Psychoactive Substances
_____ Sexual Activity
_____ Other:_____
_____ I DO NOT give permission for the therapist to withhold any of the above information

I understand the following:

If I sign this consent, I revoke it at any time by doing so in writing. However, if I revoke this consent, this does not give me the right to obtain information that was given to the staff of Cornerstone Wellness Center in reliance on this agreement.

This agreement is subject to the laws of the United States and the State of Iowa:

a. **If Federal or State law requires the disclosure of information obtained during professional services, this agreement cannot BLOCK such disclosure.**

b. **If Federal or State law blocks the disclosure of information obtained during professional services, this agreement cannot FORCE such disclosure.**

_____

Parent or Legal Guardian **Date Signed**

_____

Treatment Provider **Date Signed**