BILLING INFORMATION FORM

CLIENT:_____ GENDER: F M BIRTHDATE:_____

HOME PHONE: (____)_____ WORK PHONE:(___)_____ EXT:_____
May we identify Cornerstone?_____ May we contact you at work?_____

EMAIL: _____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMPLOYER:_____ SOC. SEC. #:_____

SPOUSE'S NAME:_____ WORK PHONE:(___)_____

SPOUSE'S EMPLOYER:_____

NEAREST RELATIVE
NOT LIVING WITH YOU: _____ PHONE: (___)_____

PHYSICIAN: _____ PHONE: (___)_____

IN EMERGENCY CONTACT: _____ PHONE: (___)_____

WHO REFERRED YOU? _____

MAY WE THANK THEM? [ ] YES (SIGNATURE)_____ [ ] NO

I WILL BE PAYING TODAY BY: [ ] CASH [ ] CHECK [ ] MASTERCARD OR VISA

☐ I would like to put my Card information on file: (*Fill out below*)

Card #:_____ Expiration Date: _____ Security Code: _____

SIGNATURE: _____ DATE: _____

☐ I would **NOT** like to put my Card information on file. ***(By making this section I understand that I will receive statements via mail and any unpaid balances may be subject to collections.)***

I understand and agree that **regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered,** and that payment is due at the time those services are rendered. I understand that the hourly rate for the requested services is $120.00; $150.00 for diagnostic session. I further understand that the initial one to three sessions are for the purpose of evaluation (i.e., to determine whether or not a treatment relationship will be established) and as such do not guarantee acceptance as a Cornerstone client. **I have read all the information on both sides of this sheet and agree to the conditions set forth. I certify this information is true and correct to the best of my knowledge and will notify you of any changes in my status or the above information.**

SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____

CORNERSTONE COUNSELING OF ASHLAND, LLC

502 Claremont Ave.
Ashland, OH 44805
419.289.1876
Fax: 419.281.6430

ABOUT FINANCIAL ARRANGEMENTS AND MENTAL HEALTH SERVICES

We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

FEE SCHEDULE

Our standard counseling fee is $120.00 payable at each visit. **(The initial diagnostic session is $150.00)** Most insurance policies cover some percentage of outpatient counseling. You should find out the following information **prior** to your first visit to our office:

1. **What is my deductible? Have I met my deductible yet?**
   You are responsible to pay the full fee of services until your deductible is met.

   PLEASE NOTE: We strongly encourage you to contact your insurance company BEFORE your first session. Cornerstone will not be responsible for denial of claims.

3. **What percentage of the fee will your insurance company pay and what percentage of the fee are you responsible to pay?**
   Upon arrival at Cornerstone, clients are expected to pay **at least** their portion of the fee at each and every session. You should anticipate paying the full fee ($150) for the diagnostic session.

4. **Who receives the reimbursement check?**
   Sometimes insurance companies will send the check directly to us. If this happens, then (1) you will receive a credit if you "pay-as-you-go," or (2) the payment will be added to your weekly co-payment.

   Sometimes insurance companies will send the check directly to you. If this happens, then you should expect to pay the full fee for each session.

You are ultimately responsible to pay any balance that your insurance company may not cover. We realize that you may have special arrangements with a non-custodial parent for payment of medical bills; however, we do not bill third parties. You are responsible for the bill at the time services are rendered.

CANCELLATION POLICY

Because the demand for counseling is so great, we take very seriously our responsibility to be good stewards of our time and resources. **We ask that you give us at least a 24-hour notice of your intention to cancel any counseling appointment. Failure to show without notice, or same-day cancellations will result in the client being billed the FULL AMOUNT due Cornerstone for that session. We maintain a 24-hour answering machine 419-289-1876 or 1-800-778-3356 in case an appointment must be broken.**

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

The counselors at Cornerstone Counseling of Ashland operate on a value system rooted in helping. We respectfully ask that you help us to help you and do your best to attend all scheduled appointments. **If for any reason you are unable to attend a session, we require a call at least 24 hours before the scheduled session. A no-show charge of $50.00 will be billed in the case of a missed appointment and sessions canceled on the day of the appointment will receive a late cancellation fee at your counselor's discretion.** These additional fees are not covered by insurance and must be paid in full before any additional appointments can be scheduled.

We offer reminder phone calls, emails, or text messages before your appointment, but there may be times we are unable to reach you. It is important to understand that your counselor has set aside an hour just for you and you are still responsible for the appointments that you set.

☐ **I would like to receive a reminder...**

- ☐ phone call
- ☐ text message
- ☐ email

You can contact me at: _____

☐ **I would <u>not</u> like to receive a reminder phone call, text message, or email.**

APPOINTMENTS AND FEES

First 50 minute appointment with therapist	$150.00
Regular 50 minute session with therapist(individual, couples, or family)	$120.00
Group therapy session	$50.00
Testing (MMPI) – Not billable to insurance	$100.00
Court testifying, depositions, and any court related work	$150.00/hr
No Show/Late Cancellation - Not billable to insurance	$50.00

I understand what I have read and I acknowledge that I am financially responsible.

_____

Client Signature Client Printed Name Date

CORNERSTONE COUNSELING OF ASHLAND, LLC

Consent to Treat

Client Name _____
LAST FIRST MIDDLE

DOB _____ **Date of Consent** _____

Purpose and Nature of Consent: To gain permission from the client or the custodial parent or other legal guardian of a minor to provide needed services.

Types of Service(s) to be Provided: I hereby authorize **Cornerstone Counseling of Ashland** to provide the following services to the above named client:

Individual Counseling Group Counseling Psychological Assessment

Case Management Telebehavioral Health Other: _____

Telebehavioral Health: During the telemedicine consultation, details of your medical history, personal history, diagnoses, risk assessment, therapeutic intervention, diagnostic testing, and progress will be discussed with mental health professionals through the use of interactive video, audio, and telecommunication technology. Benefits include improved access to medical care by enabling a patient to remain in his/her home or work environment, a chance at more efficient medical evaluation and management, and the client can obtain expertise of a distant specialist. Risks include possible disruption or distortion by technical failures or unauthorized access by persons and, very rare, failure of security protocols causing a breach of privacy.

Confidentiality: It is my understanding that such services and any information derived there from are confidential and will be treated as such by the staff of Cornerstone. Information regarding such services cannot be provided without written permission from the above named client or, if a minor, the parent/guardian of the above named client. Exceptions to confidentiality include: Danger to self, mandatory reporting of child abuse, or others.

Consent: I voluntarily consent to the treatment described above. By doing so, I am stating that I am the above named person or I am the custodial parent and/or legal guardian of the above named person and no threat or coercive measures have induced me to sign this consent form. I hereby further release Cornerstone from all legal responsibility or liability that may arise from the act(s) that I have authorized above.

Withdrawal of Consent: I understand that I may withdraw this consent at any time except to the extent of action already taken based upon my consent. Such withdrawal must be done formally and in writing, signed and dated.

Client Signature: _____ Date: _____

Parent/Guardian Signature (if a minor): _____ Date: _____

Witness: _____ Date: _____

CORNERSTONE COUNSELING OF ASHLAND, LLC

502 Claremont Ave.
Ashland, OH 44805
419.289.1876

INSURANCE SIGNATURE REQUIREMENT

(in lieu of insurance form)

Client: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Cornerstone Counseling of Ashland, LLC to release any information acquired pertaining to the billing process.

_____ _____

Client (or guardian) Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE: I authorize payment of medical benefits to Cornerstone Counseling of Ashland, LLC for services rendered.

_____ _____

Client (or guardian) Date

Cornerstone Counseling of Ashland, LLC

Personal Wellness Survey

Name _____ Date _____

Scoring Key: 1 = No Symptoms 2 = Mild Symptoms 3 = Moderate Symptoms
4 = Serious Symptoms 5 = Severe Symptoms

Migraine Headaches	1 2 3 4 5	Epilepsy/Convulsions	1 2 3 4 5
Colon or Bowel Trouble	1 2 3 4 5	Diabetes	1 2 3 4 5
Stomach/Duodenal Ulcer	1 2 3 4 5	Hyperglycemia	1 2 3 4 5
Acid Reflux	1 2 3 4 5	Hypoglycemia	1 2 3 4 5
Heart Burn	1 2 3 4 5	Joint Pain	1 2 3 4 5
Inflammation	1 2 3 4 5	Back Pain	1 2 3 4 5
Hearing Loss	1 2 3 4 5	Eye Problems	1 2 3 4 5
Angina	1 2 3 4 5	High Blood Pressure	1 2 3 4 5
Heart murmur	1 2 3 4 5	Irregular Heart Beat	1 2 3 4 5
Kidney/Bladder infections	1 2 3 4 5	Arthritis	1 2 3 4 5
Emphysema	1 2 3 4 5	Underactive Thyroid	1 2 3 4 5
Dermatitis	1 2 3 4 5	Overactive Thyroid	1 2 3 4 5
Overweight	1 2 3 4 5	Sleeping too little	1 2 3 4 5
Underweight	1 2 3 4 5	Sleeping too much	1 2 3 4 5
Low energy	1 2 3 4 5	Feeling "Wired"	1 2 3 4 5
PMS	1 2 3 4 5	Feeling "Foggy"	1 2 3 4 5
Menstrual difficulties	1 2 3 4 5	Feeling Anxious	1 2 3 4 5
Hot flashes	1 2 3 4 5	Feeling Depressed	1 2 3 4 5

Current Medications:

Name _____ Amount _____ Purpose _____

Name _____ Amount _____ Purpose _____

Name _____ Amount _____ Purpose _____

Chronic illness _____ Surgery for _____

Miscarriage or Abortion _____ Infertility _____

Do you smoke? _____ Yes _____ No How much? _____ Age at first cigarette? _____

If you smoked in the past, at what age did you quit? _____

Do you drink alcohol? _____ Yes ____ No How much? _____ Age at first drink? _____

If you drank in the past, at what age did you quit? _____

Do you use street drugs? _____ Yes _____ No Age at first use? _____

If you used street drugs in the past, at what age did you quit? _____

What drugs have you used? _____

When? _____ How much? _____

Do you have any sexual concerns? _____ Yes _____ No

Have you ever had any contact with the police/legal system? _____ Yes _____ No

During the past week... 1 = None 2 = Very Little 3 = Some 4 = Occasionally 5 = Frequently 6 = A lot

How concerned or worried have you been about your health?	1 2 3 4 5 6
How anxious, nervous, or tense have you been?	1 2 3 4 5 6
How much have you been bothered by feelings of guilt?	1 2 3 4 5 6
Have you ever felt super-efficient or like you have unlimited energy, special talents, or powers?	1 2 3 4 5 6
How depressed have you felt?	1 2 3 4 5 6
How irritable or angry have you been?	1 2 3 4 5 6
How much distrust of others have you felt?	1 2 3 4 5 6
Did you hear or see things around you that others did not see?	1 2 3 4 5 6
How much difficulty have you had with your thinking?	1 2 3 4 5 6

Is there anything else you would like your therapist to know? _____

_____

_____

_____

_____

Cornerstone Counseling of Ashland, LLC

Personal Information Questionnaire

Name: _____ Age: _____ Date: _____

What goal or goals would you like to accomplish while in counseling? _____

_____

_____

What are your strengths? _____

_____

_____

Have you ever been to a counselor before? _____ When? _____ Where? _____

What did you learn from your previous counseling sessions? _____

_____

Married _____ Widowed _____ Single _____ Separated _____ Divorced _____

If you are in a relationship, is your relationship? ____ Good ____ Fair ____ Poor ____ Very Poor

If you have children, please indicate how many, their names, how old, and if they are still dependent on you or if they have left home. _____

_____

_____

How would you describe your father? _____

How would you describe your mother? _____

Please describe any brothers and sisters that you may have. _____

_____

_____

Who is or was the most supportive person in your life? _____

What level of education have you completed? _____ Major? _____

What do you remember about your school experience? _____

_____

How would you describe your childhood? _____

_____

Were there any childhood experiences that continue to be of concern to you? _____ Yes _____ No

Would you say you remember your childhood ____ A lot ____ Some ____ Not much ____ Nothing

Would you say your childhood memories are ____ Pleasant ____ Average ____ Painful

Do you feel that you have been abused? (bullied or discriminated against)

____ Yes ____ No ____ I'm not sure

Have you ever been suicidal?

____ Yes (past) ____ Yes (present) ____ No

____ I think about it sometimes, but I would never do it

If yes, please describe: _____

_____

If you are currently employed, please describe your work environment. _____

_____

Do you enjoy your current occupation? _____

How do you get along with your coworkers? _____

Did you serve in the military? ____ Yes ____ No

If yes, where stationed? _____ When? _____

How would you describe the spiritual aspects of your life?

____ Very important ____ Important ____ Unimportant ____ Painful ____ Unnecessary

Do you currently attend church? ____ Yes ____ No ____ Denomination? _____

Is your faith/spirituality helpful to you? ____ A lot ____ A little ____ Not at all

Do you have any plans for the future? ____ Yes ____ No

Please explain: _____

_____