



502 Claremont Avenue • Ashland, Ohio 44805 • 419-289-1876 • Fax 419-281-6430

ABOUT CORNERSTONE MENTAL HEALTH SERVICES AND PAYMENT POLICY

We are committed to providing you with the best possible care. We are contracted with or “in-Network” with multiple private and public insurance companies/carriers including specific Medicaid plans and Medicare but will serve “out-of-network” or “self-pay” patients as well. If you have medical health 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.

PLEASE NOTE: We strongly encourage you to contact your insurance company **BEFORE** your first session. They should be able to confirm or correct your eligibility and benefits or the estimated costs provided to you by Cornerstone.

Medical health insurance can be complicated. The following is a short explanation along with a few terms and definitions to help your understand how our billing process works. If you would like more information please visit <https://www.healthcare.gov/glossary/> or <https://www.cms.gov/glossary> for term definitions.

After your first visit, the billing process begins. First, we submit a claim to your insurer. Next, the insurer reviews the claim, or what is called “adjudication,” and then processes the claim to either pay their portion, or deny the claim, based on your contracted benefits. This process produces the EOB (Explanation of Benefits), EOP (Explanation of Payment), or RA (Remittance Advice), which is sent to both the provider and the patient. Finally, we will bill you for any remaining patient responsibility such as deductible, co-insurance, or copay. Regardless of coverage, payment is due at the time of service.

- Deductible: The amount you must pay before insurance begins to pay. This amount should not be the same as the billed amount. This amount is based on your insurance plans “allowed amount”
- Allowed amount: The maximum amount a plan will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate”
- Disallowed amount: An adjustment or write off amount equal to the difference between the billed amount and the allowed amount
- Co-insurance: The percentage of the allowed amount you must pay based on your insurance plan AFTER the deductible is met
- Co-payment or “Copay”: A fixed amount you pay for a covered health care service

If you notice there is a discrepancy between the EOB from insurance and the bill from Cornerstone please bring this to our attention! We are committed to keeping our records as accurate as possible.

LATE CANCELLATION OR NO-SHOW POLICY

The demand for counseling is great, so we take very seriously our responsibility to be good stewards of our time and resources. We require you give us a call **AT LEAST** 24-hours notice of your intention to cancel any counseling appointment. Failure to show without notice or same-day cancellations may result in you being billed a fee based on the following or on the counselor's discretion as we understand some times extenuating circumstances can happen.

- First late cancellation or no-show = \$0.00 / “Grace”
- Second late cancellation or no-show = \$25.00
- Third or subsequent late cancellation or no-show = \$50.00

After two no-shows, any appointments currently on the books will be canceled and removed from our schedule. Any further appointments will not be scheduled until your balance is paid in full.

However, if you are covered under a **Medicaid** plan, per Ohio law, we are prohibited from charging you a late cancellation or no-show fee. Multiple consecutive or frequent late cancellations or no-shows may result in your **discharge** as a patient of Cornerstone for noncompliance with this policy. Any appointments currently on the books will be canceled and removed from our schedule. If requested, you will be provided references to other counseling providers.

SERVICE FEES

CPT CODES / ADD-ON CODES	DESCRIPTION (ALL SERVICES ARE "IN OFFICE" / "OUTPATIENT")	2026 BASE Billed Rate
90791	INTAKE, DIAGNOSTIC EVAL(NO MEDICAL)	\$200.00
90791	SELF PAY (NO INSUR) INTAKE, DIAGNOSTIC EVAL(NO MEDICAL)	\$175.00
90837	Individual Psychotherapy 60 minute Session (53-60 min/53-89 min)	\$175.00
90837	SELF PAY (NO INSUR) Individual Psychotherapy 60 minute Session (53-60 min/53-89 min)	\$150.00
90834	Individual Psychotherapy 45 minute Session (38-52 min)	\$135.00
90832	Individual Psychotherapy 30 minute Session (16-37 min)	\$90.00
90847	Family / Couples Therapy WITH the patient present (26-50 min)	\$180.00
90846	Family / Couples Therapy WITHOUT the patient present (26-50 min)	\$180.00
(90837)+90785	ADD-ON - Interactive complexity (EMDR, play therapy, etc.)	\$30.00
(90837)+99354	ADD-ON - Individual Psychotherapy Extended Session (90-134 min/1:30-2:14 hrs)	\$90.00
(90847/6)+99354	ADD-ON - Family / Couples Therapy Extended Session (80-124 min/1:20-2:04 hrs)	\$90.00
90839	Individual Psychotherapy for Crisis/Emergency (53-60 min/53-89 min)	\$180.00

OTHER FEES

- MMPI Testing (Not billable to insurance) = \$150.00
- Court testifying, depositions, and any court-related work = \$150.00 per hour

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I the undersigned hereby acknowledge that I have read and understand all the information on both sides of this sheet, and agree to the conditions set forth by the payment policies of Cornerstone Counseling of Ashland, LLC.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN (If minor): _____ DATE: _____

WITNESS: _____ DATE: _____

PAYMENT METHOD

I will be paying today with the following:

- CASH
- CHECK
- DEBIT/CREDIT CARD

FUTURE METHOD

I consent to and would like to put my Card information on file as follows

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

I do NOT consent to and would NOT like to put my card on file. *(By making this selection I understand that payment is due at the time of service. If I am unable to pay, I will receive statements via mail and any unpaid balances may be subject to collections.)*

SIGNATURE: _____ DATE: _____

CORNERSTONE COUNSELING OF ASHLAND, LLC
Consent for Treatment and Insurance Authorization

PATIENT'S NAME: _____ DOB: _____

CONSENT FOR TREATMENT

I voluntarily consent and hereby authorize Cornerstone Counseling of Ashland, LLC to provide services to the above named patient. 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 below.

Services include but are not limited to: Individual Counseling/Psychotherapy, Family Counseling, Group Counseling, Diagnostic Assessment, Case Management, Telebehavioral Health, etc.

It is my understanding the services and any information is 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.

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.

INSURANCE AUTHORIZATION

I hereby authorize Cornerstone Counseling of Ashland, LLC to release any information acquired pertaining to the billing process. I authorize my insurance company to pay benefits directly to Cornerstone Counseling of Ashland, LLC for services rendered.

I understand I may be financially responsible for any charges not covered by insurance based on the insurance network contract application. I understand the estimated costs or benefits given to me by Cornerstone Counseling of Ashland, LLC are not guaranteed to be accurate or complete. I understand that payment of benefits are subject to all terms, conditions, limitations, and exclusions of the insurance contract at the time of service. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN (If minor): _____ DATE: _____

WITNESS: _____ DATE: _____

ADULT PATIENT INFORMATION FORM

PATIENT'S LEGAL NAME: _____ GENDER: F M DOB: _____

PREFERRED NAME: _____ SOC. SEC. #: _____

MOBILE PHONE: (_____) _____ OTHER PHONE: (_____) _____

EMAIL: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MARITAL STATUS: _____ SIGNIFICANT OTHER'S NAME: _____

EMPLOYMENT STATUS: _____ STUDENT STATUS: _____

EMERGENCY CONTACT: _____

RELATION: _____ PHONE: (_____) _____

ELECTRONIC COMMUNICATION CONSENT

We offer reminders before your appointment, but there may be times we are unable to reach you. Please note that we send these reminders as a courtesy, but you are responsible for the appointments that you set. Please respect that the counselor has set aside this hour just for you and if you cancel on the same day or do not show up, then you may be subject to a late cancellation or no-show charge. Refer to our "Late Cancellation or No-Show Policy" for more information.

I consent to and would like appointment reminders and administrative communication via the following.

Phone Call: (_____) _____

Text Message: (_____) _____

Email: _____

I would NOT like to receive appointment reminders.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

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: _____

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

502 Claremont Ave., Ashland, Ohio, 44805 – Phone: 419.289.1876 Fax: 419.281.6430

Authorization for Use or Disclosure of Protected Health Information

Client's Name (print): _____ DOB: _____

I hereby authorize Cornerstone Counseling of Ashland (check one):

_____ To Disclose to: _____

_____ To Disclose to and Receive From: _____

_____ To Request/Receive From: _____

(Full Name/Title, Address of Person/Agency)

The following information (check all that apply):

_____ Full Clinical Records _____ Diagnosis _____ Assessment Results (including test results)

_____ Treatment Plan _____ Summary of Treatment Participation _____ Discharge Summary

_____ Other (specify) _____

Purpose(s) or Need for disclosure and/or receipt of protected health information:

Expiration Date: This consent (unless revoked) expires:

90 days from date of authorization listed below

Other: (specify): _____

Statement of Understanding:

1. I understand that the protected health information used and/or disclosed based upon this authorization may be re-disclosed to additional parties and is therefore no longer protected.
2. I understand that I may revoke or cancel this authorization at any time by signing and dating the revocation section below. I further understand that doing so does not apply to the extent that persons authorized to use or disclose my health information have already acted upon this authorization.
3. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.
4. I understand that I have the right to inspect and/or obtain a copy of any protected health information disclosed pursuant to this authorization.

Signature of (circle one): Client/Parent/Guardian/Personal Representative Date

Signature of witness/title Date

=====
Revocation: I hereby revoke this authorization. I understand that revocation does not apply to the extent that those authorized to use or disclose my information have already acted in reliance on this authorization.

Client, Guardian, or Representative Signature Date