Cornerstone
COUNSELING OF ASHLAND
*Bringing hurting people to healing and joy.*
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 follwing:

☐ 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: _____

# MINOR PATIENT INFORMATION FORM

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

PREFERRED NAME: _____ SOC. SEC. #: _____

MOBILE PHONE:(_____)_____ CONTACT'S NAME: _____

OTHER PHONE:(_____)_____ CONTACT'S NAME: _____

EMAIL: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

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**CUSTODIAL PARENT:** _____ RELATION: _____

SIGNIFICANT OTHER'S NAME: _____ RELATION: _____

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**NON-CUSTODIAL PARENT:** _____ RELATION: _____

SIGNIFICANT OTHER'S NAME: _____ RELATION: _____

MOBILE PHONE:(_____)_____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

**CUSTODY & COURT-INVOLVED SERVICES DISCLAIMER**

Cornerstone Counseling of Ashland, LLC provides clinical treatment only and does not conduct custody evaluations or forensic assessments unless contracted in writing. Records may be subpoenaed and additional fees may apply for court-related services.

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EMERGENCY CONTACT: _____

RELATION: _____ PHONE: (_____)_____

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**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**
CHILD DEVELOPMENTAL HISTORY RECORD

**A. IDENTIFICATIONS**

Child's Name:_____ Date:_____

Birthdate:_____ Age:_____ Grade:_____ School: _____

Person(s) completing form:_____

Mother's Name:_____ Age:_____

Father's Name:_____ Age:_____

Siblings (Ages Included):_____

Child's parents are currently: ❒ Married ❒ Divorced ❒ Separated ❒ Never married ❒ Other:_____

Child's legal guardian is:_____

Custody Arrangement:_____

**B. DEVELOPMENT** – Please fill in any information you have on the areas listed below regarding this child.

**Pregnancy** – During pregnancy, did the mother:

See a doctor regularly? ❒ No ❒ Yes Smoke? ❒ No ❒ Yes

Use substances that could have affected the pregnancy? If so, specify _____

Experience any of these? (check all that apply)

❒ Anemia ❒ High Blood Pressure ❒ Toxemia

❒ Bleeding ❒ Flu ❒ Viral Infections ❒ Vomiting ❒ Emotional Difficulties

Experience any illness or injuries? ❒ No ❒ Yes If so, what? _____

_____

Experience any trauma, grief, or loss? ❒ No ❒ Yes If so, what? _____

_____

Take medications? ❒ No ❒ Yes If so, what medications? _____

_____

**Delivery**

How long was the mother in labor? _____ Hours

Was the mother given medications? ❒ No ❒ Yes If so, what? _____

Was the child's birth by: ❒ Vaginal Birth ❒ C-Section

Did the mother have: ❒ General Anesthesia ❒ Local Anesthesia ❒ No Anesthesia

Was labor induced? ☐ No ☐ Yes Was this a breech delivery? ☐ No ☐ Yes

Was the child full-term? ☐ No ☐ Yes Weight at birth?_____

Were forceps used? ☐ No ☐ Yes

Were there any complications? ☐ No ☐ Yes If so, what?_____

_____

**Post-Delivery** (while in hospital) – After delivery, did the child experience any of the following:

Delays in breathing? ☐ No ☐ Yes Delays in crying? ☐ No ☐ Yes

Jaundice (yellow)? ☐ No ☐ Yes Cyanosis (blue)? ☐ No ☐ Yes

Vomiting? ☐ No ☐ Yes Diarrhea? ☐ No ☐ Yes

Birth defects? ☐ No ☐ Yes Explain:_____

**The First Few Months of Life**

Breast-fed? ☐ No ☐ Yes If so, how long? _____

Any allergies? ☐ No ☐ Yes If so, what? _____

Any unusual reactions to vaccinations? ☐ No ☐ Yes If so, what? _____

Sleep problems? ☐ No ☐ Yes If so, what?_____

Early temperament/personality?_____

_____

Did the child have any vision or hearing difficulties? ☐ No ☐ Yes If yes, please specify:_____

_____

Any language or speech difficulties? ☐ No ☐ Yes If so, please specify:_____

C. **HEALTH** – Did the child experience any of the following?

Operations? ☐ No ☐ Yes If so, please specify:_____

Hospitalizations (other than operations)? ☐ No ☐ Yes If yes, please specify:_____

Head injuries? ☐ No ☐ Yes If so, please specify:_____

Seizures? ☐ No ☐ Yes Fever? ☐ No ☐ Yes Poisoning? ☐ No ☐ Yes

Recurrent ear infections? ☐ No ☐ Yes Bedwetting after three years old? ☐ No ☐ Yes

Was the child clumsy? ☐ No ☐ Yes Explain:_____

_____

What medications is the child currently taking? _____

_____

Has the child taken any medications in the past?_____

**D. RESIDENTIAL PLACEMENTS, INSTITUTIONAL PLACEMENTS, OR FOSTER CARE** – List any residential placements.

| Dates | | | |
|---|---|---|---|
| From | To | Program Name/Location | Reason for Placement |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**E. SCHOOLS** – list all schools attended, starting with the current/most recent:

| School (Name, Address) | Grade | Age | Teacher |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Grades? ☐ Above Average ☐ Average ☐ Below Average

Any problems in school? ☐ No ☐ Yes What?_____

_____

May I call and discuss your child with his or her current teacher? ☐ No ☐ Yes

If yes, a **Release of Information** form **must** be signed by the custodial parent.

**F. SPECIAL SKILLS OR TALENTS OF CHILD**

List any special skills or talents your child has:

_____

_____

_____

**G. PRESENT STATUS**

Please look at the following characteristics and rate them as to how they describe your child.

1 = None 2 = Very Little 3 = Some 4 = Occasionally 5 = Frequently 6 = A lot

| | |
|---|---|
| How concerned or worried does your child seem? | 1 2 3 4 5 6 |
| How angry does your child appear to feel? | 1 2 3 4 5 6 |
| How much is your child bothered by feelings of guilt? | 1 2 3 4 5 6 |
| Have you noticed that your child tends to cry easily? | 1 2 3 4 5 6 |
| How depressed do you feel your child to be? | 1 2 3 4 5 6 |
| How distractible does your child appear to be? | 1 2 3 4 5 6 |
| Does your child miss turning in school work? | 1 2 3 4 5 6 |

| | |
|---|---|
| How frequently does your child tend to lie? | 1 2 3 4 5 6 |
| How much arguing does your child tend to do? | 1 2 3 4 5 6 |
| How much does your child procrastinate? | 1 2 3 4 5 6 |
| Do you think your child is worried about their appearance? | 1 2 3 4 5 6 |
| Do you think your child has been teased or bullied? | 1 2 3 4 5 6 |
| How would you rate your child's tendency to tease or bully others? | 1 2 3 4 5 6 |
| Does your child have difficulty with authority figures? | 1 2 3 4 5 6 |
| How often does your child miss attending school? | 1 2 3 4 5 6 |
| How difficult is it for your child to wait on what he or she wants? | 1 2 3 4 5 6 |
| How often has your child been in trouble with the law? | 1 2 3 4 5 6 |
| How often does your child show affection? | 1 2 3 4 5 6 |
| Does your child have any difficulties eating? | 1 2 3 4 5 6 |
| Do you think your child is friendly, outgoing, or social? | 1 2 3 4 5 6 |
| Does your child have any imaginary playmates or fantasies? | 1 2 3 4 5 6 |
| Does your child tend to act independently? | 1 2 3 4 5 6 |
| How often does your child obey rules, adults, etc.? | 1 2 3 4 5 6 |
| Do you think your child is responsible? | 1 2 3 4 5 6 |
| How important is spirituality to your child? | 1 2 3 4 5 6 |

**H. OTHER**

What are your goals for counseling?

_____

_____

Are there any barriers that could get in the way?

_____

_____

Does your child have any history of self-harm or suicide risk? ☐ No ☐ Yes
If so, explain: _____

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

_____

_____

# 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 therefor 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 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

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**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