BILLING INFORMATION FORM FOR MINORS

CLIENT:______________________________ GENDER: F M BIRTHDATE:______________

HOME ADDRESS:____

CITY:______________________________ STATE:______ ZIP CODE:______________

HOME PHONE:(___)__________________ May we identify Cornerstone?______________

CUSTODIAL PARENT: ______________________________ SOC. SEC. #:______________

EMPLOYER:______________________________ WORK PHONE:(___)______________
(May we contact you at work?___________)

SPOUSE'S NAME:______________________________ SOC. SEC. #:______________

SPOUSE'S EMPLOYER:______________________________ WORK PHONE:(___)______________

NON-CUSTODIAL PARENT:____

ADDRESS:______________________________________ ZIP______________

PHONE NUMBER:(___)__________________ WORK PHONE:(___)______________

WHO REFERRED YOU? ____

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

IN EMERGENCY CONTACT: ______________________________ PHONE:(___)______________

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

INSURED PARTY:______________________________ BIRTHDATE:______________

EMPLOYER:______________________________ SOC. SEC. #:______________

INSURANCE CO:____

CLAIMS ADDRESS:____

INS. CO. PHONE:(___)__________________ POLICY:______________________

I understand and agree that **regardless of my insurance status OR CUSTODY/DIVORCE AGREEMENTS, 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 <u>BEFORE</u> 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 <u>at least</u> 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

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 (circle the appropriate services):

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: __________

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 not 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

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
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?

____

____