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 $100.00; $120 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

Consent to Treat

Client Name _____
LAST FIRST MIDDLE

DOB _____ **Date of Consent** _____

Purpose and Nature of Consent: To gain permission from the custodial parent or other legal guardian to provide needed services to minors or others (i.e., those under the care of a legal guardian).

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	Psychiatric Services	Other (specify): _____

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 the custodial parent/legal guardian's written permission.

Consent: I voluntarily consent to the treatment described above. By doing so, I am stating that 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: _____ Date: _____

Parent/Guardian: _____ 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

ACKNOWLEDGEMENT 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 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 reminder phone calls prior to my scheduled appointments.

NO _____ YES _____ Preferred Phone Number _____

APPOINTMENTS AND FEE'S

First 50 minute appointment with therapist	$120.00
Regular 50 minute session with therapist(individual, couples, or family)	$100.00
Group therapy session	$50.00
Testing (MMPI) – Not billable to insurance	$75.00
Court testifying, depositions, and any court related work	$125.00/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

Child Developmental History Record

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Grade: _____

Mother's Name _____ Father's Name: _____

Relationship status of parents: _____

Legal guardian of child if applicable: _____

Step parents of child if applicable: _____

Early childhood:

List any unusual pregnancy experiences: _____

_____

List any unusual birth experiences: _____

_____

List any developmental delays in sitting, crawling, walking, talking, and potty training.

_____

_____

_____

Health:

List any hospitalizations, surgery, head injuries, seizures, or any other type of trauma:

_____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

Has your child been diagnosed with any type of chronic condition or illness?

List names and ages of child's brothers and sisters if applicable: _____

Are any of the members of this family system adopted? _____

School:

What do you believe is your child's best subject in school? _____

Generally what type of grades does your child typically receive? _____

If applicable, has your child been diagnosed with anything that you feel interferes with their performance at school? _____

Has your child's teacher noted any behavioral issues that you feel need to be addressed? _____

General Information:

What special skills or talents does your child have? _____

Is your child more comfortable making friends or being alone? _____

What is your child's favorite activity? _____

What are your child's greatest obstacles? _____

Name:_____ **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 wants?	1 2 3 4 5 6
How often has your child been in trouble with the law?	1 2 3 4 5 6

Is there anything else you would like your child's therapist to know?

_____

_____

_____

_____