

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 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: _____

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, 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	\$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

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? _____

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?
