BILLING INFORMATION FORM

CLIENT:______________________________ GENDER: F M BIRTHDATE:______________

HOME PHONE:( )____________________ WORK PHONE:( )____________________ EXT:__________
May we identify Cornerstone?________ May we contact you at work?________

HOME ADDRESS:____

CITY:______________________________ STATE:______ ZIP CODE:______________

EMPLOYER:______________________________ SOC. SEC. #:______________

SPOUSE'S NAME:______________________________ WORK PHONE:( )____________

SPOUSE'S EMPLOYER:____

NEAREST RELATIVE
NOT LIVING WITH YOU: ______________________________ PHONE:( )____________

PHYSICIAN: ______________________________ PHONE:( )____________

IN EMERGENCY CONTACT: ______________________________ PHONE:( )____________

WHO REFERRED YOU? ____

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

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 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

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

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? ______________________________________

____

____

____

____