Cornerstone Counseling
10 Hillview Drive, Westerly, RI 02891
Telephone: 401-596-8800 Fax: 401-315-8831

Client: _____
DOB: _____

CLIENT INFORMATION

Date _____

General Information
Client Name: Last_____ First _____ MI ___
Birth date _____/_____/_____ Gender: □ Male □ Female SS # _____- _____ - _____
Marital Status □ Single □ Married □ Other
Employed □ Not employed □ Full-time □Part-time
Student □ Full-time □ Part-time
Address_____ City, State, Zip _____
Home Telephone _____ Email: _____
Work Telephone _____ Cell Telephone _____
Employer _____ Employer Phone _____
Employer Address_____ City, State, Zip _____

Referred by _____ Telephone _____

Emergency Contact
Name _____ Relationship to Client _____
Address _____ Home Telephone _____
Cell Telephone _____Work Telephone _____

Responsible Party (if Client is a minor)
Name: First_____ MI ___ Last _____
Address_____ City, State, Zip _____
Home Telephone _____ Social Security # _____- _____ - _____
Employer _____ Employer Address _____
Work Telephone _____ Birth date _____/_____/_____
Cell Telephone _____ Gender □ Male □ Female
Email: _____

INSURANCE INFORMATION

□ **No Insurance, Private Pay for Services**

Primary Insurance Company Info
Client's relationship to Insured Person □ Self □ Spouse □ Child □ Other
Insured's Name: Last_____ First _____ MI ___
Birth date _____/_____/_____ **Gender**: □ Male □ Female
Marital Status □ Single □ Married □ Other
Employed □ Not employed □ Full-time □Part-time **Student** □ Full-time □ Part-time

Insured's Address_____ City, State, Zip _____
Home Telephone _____ Email: _____
Work Telephone _____ Cell Telephone _____
Employer _____ Employer Phone _____
Employer Address_____ City, State, Zip _____
Insurance Company _____
Insured's Policy ID # _____
Insured's Group Policy Number _____
Effective Date _____ Insurance Plan Name _____
Any Other Health Plan □ No □Yes:
□Medicare □Medicaid □Champus □ChampVA □Group □FECA □Other
Policy Holder's Military Status: □ N/A □ Active □ Retired □ Deceased □ Discharged

Secondary Insurance Company Info □N/A
Client's relationship to Insured □ Self □ Spouse □ Child □ Other
Insured's Name: Last_____ First _____ MI ___
Birth date _____/_____/_____ **Gender**: □ Male □ Female
Marital Status □ Single □ Married □ Other
Employed □ Not employed □ Full-time □Part-time **Student** □ Full-time □ Part-time

Insured's Address_____ City, State, Zip _____
Home Telephone _____ Email: _____
Work Telephone _____ Cell Telephone _____
Employer _____ Employer Phone _____
Employer Address_____ City, State, Zip _____
Insurance Company _____
Insured's Policy ID # _____
Insured's Group Policy Number _____
Effective Date _____ Insurance Plan Name _____
Any Other Health Plan □ No □Yes:
□Medicare □Medicaid □Champus □ChampVA □Group □FECA □Other
Policy Holder's Military Status: □ N/A □ Active □ Retired □ Deceased □ Discharged
Other Information: _____
_____

INFORMED CONSENT FOR TREATMENT

I hereby give my permission and consent for treatment to Cornerstone Counseling. I understand that this will encompass the intake and diagnostic assessment process, as well as any therapies, which may be recommended.

I acknowledge that my rights as a client have been supplied to me. I have had an opportunity to ask any questions which I may have about my rights as a client of Cornerstone Counseling.

I understand and acknowledge that strict confidentiality is practiced and assured, with the following exceptions:

1. In the event that I have signed a Release of Information Consent Form for specified individuals or agencies;
2. In the event that there is a court order, signed by a duly appointed or elected judge, for release of my records;
3. In the event that I am perceived to be danger to myself or others;
4. In the event that I am suspected of abusing children or other vulnerable individuals;
5. In th event that I report that I was physically or sexually abused before the age of eighteen; or
6. In the event that representatives of a funding source for my services require that my record(s) be made available with my written consent.

I understand that all treatment and evaluation at Cornerstone Counseling, is voluntary, and that I may cease treatment or evaluation at any time.
I understand and give my informed consent to the provision of emergency medical procedures, including transport to and from treatment at a local general hospital emergency room should Cornerstone Counseling staff deem it necessary.
I have read and/or had the above explained to me, and voluntarily give my informed consent to treatment and/or evaluation.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize and request that third party payors and/or insurance companies pay Cornerstone Counseling for covered services rendered to me or my family.
I understand that this authorization applies to those eligible charges submitted with any claims for services incurred during my/the client's treatment at Cornerstone Counseling. In addition, I give my informed consent to Cornerstone Counseling to release to any current or future insurer and its agents, and medical billing company, any information regarding me or my family's care needed to determine these benefits or the benefits payable for related services, and to contact the insurer and its agents for any information needed regarding my account. I authorize the use of this signature on all insurance submissions.

FINANCIAL AGREEMENT

I (We) understand that Cornerstone Counseling will make every attempt to file appropriate forms with my/our insurance carriers. However, I (We) understand that the financial responsibility for all services rendered to the client rests with the financial guarantor, regardless of any insurance coverage.
I (We) agree to pay fees on the day of service unless other arrangements have been made with Cornerstone Counseling staff.
I (We) understand that there will be a $60 fee for any appointment canceled without 24 hour advance notice.
I (We) hereby agree to pay all charges incurred for professional care and services received from Cornerstone Counseling.

CLIENT RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS

1. You are entitled to be informed of your rights, in a way you can understand.
2. In cases of persons not legally competent, your parents, relatives, or guardian(s) should be informed of these rights.
3. You have the right to receive treatment no matter what your race, sex, age, creed, mental or physical handicapped status, national origin, marital status, or religious or political opinions or affiliations.
4. You have the right to be treated with courtesy, respect, and full recognition of human dignity and individuality.
5. You have the right to receive treatment in the least restrictive environment that is available, adequate, appropriate, and in compliance with relevant laws, rules, and regulations.
6. You have the right to a treatment plan and a discharge plan, to your participation in the development of these plans, and to your being informed about all aspects of your treatment.
7. You have the right to receive treatment according to your treatment plan, and a right to refuse such treatment.
8. You have the right to have any and all of your allegations of abuse reported to local law enforcement agencies.
9. You have the right to consult with or be represented by a lawyer in matters relating to your care.
10. You have the right to access an outside physician of your choice, at your expense.
11. All of the information recorded in your record, in accordance with medical record policy, is confidential. However, you have the right to have access to your files.
12. You have a right to know if any tape recorders or cameras will be used as part of your treatment plan. You have a right to refuse their use and to understand what will happen if you refuse to have them used.
13. You have a right to know how much your treatment costs, who pays for your treatment, and any limit to amount of treatment they will pay for.
14. You have a right to be informed about any changes (and their reasons) in your treatment.
15. You have a right to voice your complaints, and the Cornerstone Counseling staff is expected to respect your complaints, and to review them.

CLIENT RESPONSIBILITIES

1. You are expected to attend all scheduled appointments. You are expected to be on time for appointments. If you need to cancel or reschedule an appointment with a staff member, you must call him/her at least 24 hours in advance to avoid a payment of $60.
2. If you need to change the appointment day or time, please discuss this with your therapist. We will do everything possible to provide an alternative appointment time that is convenient.
3. You are responsible for any cost of treatment or co-payment should your insurance company (or other third party payor) not fully reimburse Cornerstone Counseling for services provided to you.

I have read this policy, understand it, and agree to its provisions. I understand that a copy of this form is available upon my request.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have:
- been provided with a copy of this Notice of Privacy Practices, or had one made available to me prior to consenting to the use and disclosure of my Protected Health Information for treatment, payment and operations;
- had the opportunity to ask any questions regarding my rights relating to the use and disclosure of my Protected Health Information; and
- been told that I may request restrictions on the use and disclosure of my Protected Health Information.

OFFICE POLICIES

Current Office Hours -Effective 12/1/15
Monday, Tuesday, Wednesday, Thursday 9:00 am to 4:00 pm

Fees - Effective 4/1/09
$155 Initial Intake Assessment (first appointment)
$155 Family, Couples, and extended Individual Sessions
$110 Individual Sessions
$ 60 Group Sessions

Sessions
Although the first appointment can be longer, most appointments are 45 minutes in length. Appointments
cannot go beyond the allotted time, so please arrive on time for your scheduled appointment.

Confidentiality
Information you provide to us is considered confidential, and will not be released without your written
permission. We are governed by state and federal regulations as noted in the information enclosed in this
intake packet. Please consult office staff for any questions concerning the confidentiality of your records.

Changes in Personal Information
Please inform our office as soon as possible of any changes in your information, such as a change of address, a change of marital status or a change in insurance companies.

Payments

Co-payments are due at each session unless other arrangements have been made. You may pay by check,
money order, credit card, debit card, or cash. If circumstances prevent you from making a payment at the
time of service, please discuss this with your therapist.

Missed appointments

You are responsible for keeping appointments in a timely manner. Unless there are extraordinary circumstances, you will be charged a $60 fee if 24-hour notice is not received. Please note that insurance
companies will not cover this fee. The fee will be payable on or before your next appointment. Should you miss a regularly scheduled appointment, please contact your therapist as soon as possible to verify your next scheduled appointment. Since continuity is an important aspect of your care, treatment may be terminated after two missed appointments, and a referral made available to another area provider.

Children and Pets

Please do not plan to bring young children or pets to the office as no supervision is available during sessions.

Emergencies

In case of a mental health emergency, please call 911 or go to the nearest emergency room. Should you need to reach me for an urgent matter during office hours, please call the office telephone number and leave a message on my voice mail, which I check several times a day. Should you experience an urgent situation when the office is closed or I am unavailable, please call my cell phone number at 401-595-3191 and I will return your call as soon as possible. Routine telephone calls are usually returned within 24 hours. During counseling sessions, your therapist does not answer incoming telephone calls unless it is an emergency.

Thank you in advance for your compliance with our office policies

I have read and agree to the all the above information contained in this document

_____ _____

Client/Guarantor Date

_____ _____

Staff Witness Date