Cornerstone Counseling Center, P.C.

Name_____ SS#_____

Street _____ City _____

State_____ Zip_____ Date of Birth _____Marital Status _____

Telephone(s) H_____ W_____ ext _____

Email: _____ Cell: _____

Education_____Occupation_____

Employer_____

Employer Address_____

City_____ State _____ Zip_____

Insurance Company_____

Name of Insured_____ Date of Birth_____

Insured's Employer_____

Insured's SS#_____ Insurance ID#_____

Authorization#_____ # visits _____ Copay _____

Date of last physical examination _____ Current medical conditions/allergies:

_____

Current medications with dosage _____

_____

EMERGENCY CONTACT: _____Tel_____

Initial permission for contact or messages: at home _____ at work_____ by email _____

Signature _____ Date _____

Treatment Issues

Your cooperation in completing this section will help in formulating a plan of treatment for you. Circle those items that are a problem area for you, and put a number between 1 and 3 on the line before the item. 1 = a slight problem, 2 = a serious problem, 3 = a very serious problem. Please use the blank sections at the bottom for any problem areas not listed.

____Nervousness	____Suicidal thoughts	____ Insomnia	____ Ambition
____Children	____Shyness	____Career choices	
____Concentration			
____Separation	____Bowel troubles	____Nightmares	____Stress
____Drug use	____Depression	____Appetite	____Marriage issues
____Anger	____Sexual problems	____Parenting	____My thoughts
____Sleep	____Stomach trouble	____Divorce	____Fears
____Relaxation	____Alcohol use	____Finances	____Work issues
____Temper	____Self -control	____Friends	____Tiredness
____Energy	____Health problems	____Unhappiness	____Memory
____Loneliness	____Legal matters	____Education	____Headaches
____Self- esteem	____Making decisions	____Organization	____Panic attacks
____Mood swings	____Relationship issues	____Tension	____Food

____ Smoking _____Other _____

Signature_____Date_____

INFORMED CONSENT

Please read the following very carefully. If you have any questions please ask your therapist. Our purpose is to help you solve the issues that brought you here. We recognize that informed consent about your treatment and your privacy is important. Thus, we assure your confidentiality, unless you authorize us in writing to release information. The following instances are exceptions:

- In cases of child or elder abuse by law
- With the presumption of imminent harm to yourself or to another
- To comply with a court order demanding our records
- For purposes of professional consultation with members of our agency
- To pursue payment or seek authorization to render services as required by your payor (Insurance company, HMO, PPO, EAP etc.) This may include calling, mailing or faxing treatment reports as required for continued authorization of services.
- To pursue payment for unpaid accounts

If you are using health insurance the following applies:

- It is your responsibility to understand the procedures and the limits of your plan. Your insurance company sets the amount that we receive and the co-payment or deductible that you owe. These are due at the time of service.
- If for any reason your insurance company denies payment, you are responsible for the full fee.
- Scheduling an appointment means professional time is reserved for you. At least 24 hours notice is required to cancel an appointment. For any missed or cancelled appointments without 24 hours notice, a $25 fee is assessed to you.
- Telephone consults cannot be billed to your insurance company. We do not charge for telephone consults lasting less than 5 minutes. Telephone consults of more than 5 minutes with you or someone that you authorize, are billed to you at the rate of $70 per hour after the first five minutes.
- Written reports for you or to someone that you authorize are billed at the rate of $70 per hour.

If you are <u>not</u> using health insurance you agree to pay $ _____per session due at the time of service.

For Emergencies: Your therapist can be reached via 978-828-8232 in the event of an emergency. If you get a voice mail, please leave a detailed message. We make every effort to respond immediately in these situations, but there could be a technological failure or other reasonable explanation. If you cannot wait for the therapist to respond, go to a local hospital immediately and ask for the on-call mental health provider and have them call the therapist as well.

Treatment Planning: Your therapist will discuss your treatment plan with you and answer all questions you may have about the rationale and duration of treatment.

Your signature below acknowledges that you have read, understand and agree to the above terms and that you have reviewed the separate handout on Privacy Practices.

_____Date_____

Cornerstone Counseling, P.C.

Authorization to Release/Obtain Medical Information
PLEASE READ CAREFULLY AND SIGN ONE OPTION BELOW:

I (we) hereby authorize and request Cornerstone Counseling to obtain and/or release confidential professional information, to/from my primary care physician for purposes of continuity of care:

Name of Physician:_____

Address:_____

Telephone:_____ Fax: : _____

I (we) understand that this consent may be revoked at any time by written instruction.

Signature_____Date_____
Parent or guardian if patient is a minor

Signature_____Date_____

OR:

I deny permission to release information to my physician.

Signature_____Date_____
Parent or guardian if patient is a minor

Signature_____Date_____