CORNERSTONE
COUNSELING CENTER

4720 Mortensen Road, #101
Ames, Iowa 50014
Ph (515) 599-8904 :: Fax(515)686-6018
www.cornerstone-counseling.com

Client Intake Information

Date: _____

Client Name: _____ DOB: _____/_____/_____

SSN: _____-_____-_____

Address: _____ Home phone: (_____)_____

_____ Work phone: (_____)_____

_____ Cell phone: (_____)_____

Occupation: _____ e-mail: _____

Employer: _____

Emergency Contact Person: _____Relationship: _____

How to best reach emergency contact person: _____

Insurance Information

Primary Insurance _____

Insurance ID # _____ Group# _____

Patient's relationship to insured (Circle one): Self Spouse Child Other: _____

Policyholder Name _____ DOB _____ Employer _____

Policyholder Address _____
(If different from patient's address)

Secondary Insurance _____

Member# _____ Group# _____

Policyholder Name _____ DOB _____ Employer _____

Policyholder Address _____
(If different from patient's address)

How did you find out about Cornerstone Counseling Center?

___ Friend ___ Relative ___ Clergy ___Website ___ Social Media ___Google Search ___Phone Book ___Doctor

___Another Service Provider ___ Other:_____

Consent for Care / Assignment of Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist/counselor to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed the particular claim.

I hereby authorize my insurance company, _____ to pay and hereby assign directly to Cornerstone Counseling Center all benefits, if any, otherwise payable to me for his/her services received by a Cornerstone Counseling Center therapist. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Cornerstone Counseling Center, will be credited to my account, in accordance with the above said assignment.

_____ _____

Signature Date

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Initial Assessment

Client Name: _____ Date: _____

Please complete the following client information (parent may complete this information for a minor):

In your own words, describe the current circumstances that has prompted you to seek counseling services:

_____

_____

In your own words, what goals/outcomes do you hope to achieve through this counseling experience?

_____

_____

What is going well in your life? What are you good at?

_____

_____

What would you like to improve?

_____

_____

Who/What is your primary support system? Who supports you?

_____

_____

Are there any issues related to race, ethnicity, sexual orientation, disability, religious affiliation, etc. that have relevance to your current situation?

_____

_____

How important is religion or spirituality to you? Is this something you want to talk about?

_____

_____

What do you do for relaxation/leisure?

_____

_____

Have you been in counseling, treatment, or hospitalized for mental health reasons in the past? If so, please note dates, names of providers, and the general benefit derived:

_____

_____

Health Information (If married, please identify answers with initials)

Name of physician _____ Phone: _____

Current Medications	Dosage	Date Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Overall Health: Very good _____ Good _____ Average _____ Declining _____

Recent Health Changes (condition, sleep, weight, etc.):

_____

_____

Significant Losses Suffered (please explain):

_____

_____

Risk Assessment

Ideations	None Noted	Thoughts Only	Plan (describe)	Intent (describe)	Means (describe)	Attempt (describe)	History (ideation and attempts)
Suicidal Ideation							
Homicidal Ideation							

Substance Abuse History

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narc					
Amphetamine					
Cocaine					
Hallucinogens					
Others					

Please mark [X] in the corresponding box next to any areas of concern you may wish to discuss during the counseling process:

	stress		anger		anxiety		parenting
	grief & loss		faith		depression		marital issues
	occupational concerns		communication		substance abuse		relational conflicts
	sexual issues		parents / in-law		childhood hurts		suicidal thoughts
	finances		appearance		past abuse		abortion

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Statement of Client's Rights

In an effort to protect your rights as a client of Cornerstone Counseling Center, you will have the following assurances:
‘

1) Informed consent shall be obtained from clients, or from parents/guardians of minor children, for participation in any treatment procedure. Education demonstration activities involving any use of audio-visual equipment or 2-way mirrors will not be used without prior permission and the client's knowledge.

2) All information obtained from or about clients shall be kept confidential and not be released or disclosed to anyone else without written consent, except for disclosures required by law, valid material and psychological emergencies, or for accrediting purposes.

In addition, clients of Cornerstone Counseling Center have the following rights:

1) The right to be treated with consideration, dignity and respect

2) The right to treatment on the basis of need

3) The right to receive treatment in the least restrictive setting

4) The right to be fully informed about services provided, recommended treatment, and outcome plans for such treatment.

5) The right to participate in the development, implementation, and the evaluation of treatment outcomes

6) The right to make choices about participation in treatment and research (such as statistics/data gathering for the purpose of improving service)

7) The right to have a statement which outlines the services being offered

8) The right to end treatment services voluntarily and without repercussion

9) The right to a plan for continuity of care (referral) as part of the process for ending services with Cornerstone Counseling Center

_____ _____
Client's or Parent/Guardian's Signature Date

_____ _____
Witness/Counselor's Signature Date

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Mental Health Counseling
Informed Consent to Treatment

I have voluntarily chosen to receive counseling services with Cornerstone Counseling Center and that I may terminate this relationship at any time.

I understand that there is no assurance that such services will result in resolution for the issues I am presenting with, and that there may be material discussed that will even have an upsetting effect upon me.

I understand that state and local laws require that my counselor report all incidents of suspected child and/or dependent adult abuse. Therefore, confidentiality is waived in such an instance.

I understand that state and local laws require that my counselor report all incidents in which there is concern for serious harm to myself and/or to others. Therefore, confidentiality is waived in such an instance.

I understand that there may be other circumstances in which the law requires my counselor to disclose confidential information.

I understand that an outside "bonded" resource may be utilized for billing services with my account. Therefore, certain limited information will be needed for billing/insurance, and other third-party payment arrangements.

I understand that my counselor may seek clinical supervision for any particular case related issues, and that my circumstances may be discussed for the purpose of clinical direction.

I have read, or have had explained to me, the Cornerstone Counseling Center "Clients Rights Policy"

I understand my right to participate in the development of the treatment plan and agree to the treatment goals. Therefore, in signing, I consent to treatment within the above arrangements.

_____ _____

Client's or Parent/Guardian's Signature Date

_____ _____

Witness/Counselor's Signature Date

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Financial Policy and Confidentiality Statement

I understand that payment is expected after each session. In the event of insurance coverage, the co-pay is due at each session.

"No show" appointments will be billed at a rate of $50.00. I understand that I must give a 24-hour notice for appointment cancellation. [An insurance company will not be billed for the "no show" fee, so client will be responsible for the entire amount.]

I understand that what is discussed is kept confidential. However, there are certain exceptions to this policy. These exceptions include issues of child abuse/neglect, dependent adult abuse/neglect, or when safety concerns are present in regard to the potential for suicide or homicide. Any other disclosure of information will only be done with my written consent.

I hereby authorize the release of information to Cornerstone Counseling Center for the purpose of insurance filing and patient billing. Only information pertaining to billing will be released and will be held in the utmost confidence.

My signature below authorizes the release of information necessary to process claims (Section 12 of the HFCA 1500 form). My signature below authorizes payment of medical benefits to be paid to Cornerstone Counseling Center for services rendered.

I agree to be financially responsible, with or without the benefit of insurance, for all charges. I understand the above stated terms and agree to the financial liability. [If the client is a minor, the parent or guardian accompanying them is responsible for payment.]

I have received a copy of Cornerstone Counseling Center "Notice of Privacy Practices".

Signed: _____ Date: _____

Witness: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

•Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.

•Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

•Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

•The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

•Most uses and disclosure of psychotherapy notes;

•Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;

•Disclosures that constitute a sale of PHI under HIPAA; and

•Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.

•The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

•The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.

•The right to inspect and copy your PHI.
•The right to amend your PHI.
•The right to receive an accounting of disclosures of your PHI.
•The right to obtain a paper copy of this notice from us upon request.
•The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of October 14, 2019, and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Steve Jones, (515) 599-8904 for more information, in person or in writing.

_____ _____

Client's or Parent/Guardian's Signature Date

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Informed Consent for Telehealth Services

Prior to starting video-conferencing services, I understand and agree to the following:

- There are potential benefits and risks of videoconferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telehealth services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and my therapist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in-person.

Client Name: _____

Signature of Client/Client's Legal Representative: _____

Date: _____

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Treatment Permission – Special Circumstances

Child's Name: _____

For parents having joint custody of a minor child, Cornerstone Counseling Center requests that both parents give permission for their child to receive counseling services. Cornerstone Counseling Center will provide services at the request of a parent only after that parent understands the potential consequences and can make an informed decision. Should the parent who initiated services decide to move forward with counseling without the other parent's consent, the following could be consequences of having the child in treatment:

Full responsibility for financial agreement regarding counseling services.
Possible return to court for violation of custody agreement.
Other:
_____
_____
_____
_____
_____
_____

I have read and understand the potential consequences outlined above. I wish to move forward and have counseling services provided to the above-named child, knowing that my child's other legal custodial parent does not support, or is not aware of, this decision.

_____ _____
Parent's signature Date

_____ _____
Therapist's signature Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ Security Code: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date