Cornerstone Counseling Center, PC
6011 Jonestown Road, Harrisburg, PA 17112
(717) 671-9520 FAX (717)671-9524

Welcome! The following information is presented to you with the belief that a clear understanding of the business aspects of our relationship, at the onset, can greatly facilitate psychotherapy. Please read all documents thoroughly and complete them, where necessary, so that you are prepared to discuss any questions during your first session.

CONFIDENTIALITY: All information obtained in the course of our relationship is fully confidential; this means that what you discuss during your sessions is confidential unless you have SIGNED a consent to release part or all of the information. Therefore, to either release or obtain information from a specific individual or agency, a Release of Information must be obtained. Exceptions to this include instances when 1) the patient is a clear danger to (a) themselves or (b) others and / or, 2) if I have reason to suspect, on the basis of my professional judgment that a child is or has been abused, I am required to report my suspicions to the Pennsylvania Department of Human Services. I am required to make such reports even if I do not see the child in my professional capacity. I am mandated to report suspected child abuse if anyone who is 14 years old or older tells me that they committed child abuse, even if the child is no longer in danger. I am also mandated to report suspected child abuse if anyone tells me that they know of any child who is currently being abused.

EMERGENCIES: In the event of an emergency, please call 717-461-6200 to reach the on-call therapist. Please leave your name and phone number for a return call. If you have not received a return call quickly enough, please call your local Crisis Intervention, 911, or visit the emergency room of your local hospital.

TELEPHONE CALLS: If it is necessary to speak to your therapist at a time other than your scheduled session, please call the office at 717-671-9520 and leave a message in the appropriate voice mailbox. If possible, your therapist will respond to your call during his/her normal business hours. Clients may incur a charge for any telephone consultation between scheduled sessions that is greater than 5 minutes in length.

LENGTH OF SESSION: Psychotherapy sessions can vary in length, depending on treatment needs. However, appointments usually last from 45 to 60 minutes. It is to your benefit to arrive a few minutes in advance of your scheduled time. Since other appointments are scheduled after yours, sessions must end on time, regardless of time of arrival.

FEES AND PAYMENT: The fee for a standard psychotherapy session is $_____. Even though your insurance company may pay all or part of any charges you incur, **you are responsible for payment at the time of each visit, unless other arrangements are made with the Billing Manager**. Outstanding balances may be sent for legal collection after 60 days, therefore adding a $50.00 fee to the total balance due. A $35.00 charge will be levied on all checks returned by a bank for any reason. In the event that your account becomes overdue and you do not make payment arrangements, services may be suspended. **It is your responsibility to determine the limits and scope of your insurance coverage. It is also your responsibility to obtain preapproval or precertification from your insurance carrier. _____ (Initials)**

CANCELLATIONS AND MISSED APPOINTMENTS: When an appointment is scheduled, that time is reserved for you. If the appointment is missed or canceled without sufficient notice, this time is not able to be used. Therefore, sessions must be canceled a minimum of _____ hours in advance or a fee will be charged for that session. (1st – $65.00; 2nd - $100.00; 3rd - $125.00) Please note that most insurance carriers do not cover missed appointments.
_____ **(Initials)**

YOUR RECORDS will be kept by this office for a period of seven (7) years after discharge, at which time they will be shredded.

If you are seeing more than one therapist at Cornerstone, these therapists may periodically consult regarding your treatment. For information regarding how we may use and disclose your Protected Health Information (PHI), please refer to your copy of "Notice of Private Practices" (NPP) or review the larger version located in the waiting room. The NPP also contains information regarding your rights to access or control your PHI.

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This is to certify that I have read, understand and have been given a copy of this document and a copy of Notice of Private Practices. I consent to release any medical or other information necessary to process this claim. In addition, this signature authorizes payment of medical benefits to the provider for services rendered.

Patient's
Signature_____Date:_____