

WELCOME TO CORNERSTONE COUNSELING CENTER, P.C.

****Please review the below forms *and their instructions* for completion:**

1. **Patient Data Form** - 2 pages to be completed.
 2. **Consent to Use and Disclose Your Health Information** - This is a HIPAA form which outlines how we may use Your Protected Health Information.
 3. **Authorization for Release of Protected Health Information** - This form gives your consent to Cornerstone Counseling Center to release information to outside parties such as insurance companies, physicians, or referral sources. *No information about your treatment will be released without your consent.*
 4. **Patient Contract** - This form provides you with information on the business aspects of our relationship. Please thoroughly read this page and discuss any questions with your therapist.
 5. **Missed Appointment Policy** - This form consents to Cornerstone's Missed Appointment and Late Cancellation Policy.
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Prior to your first session, we also encourage you to contact your health insurance company to verify your eligibility and benefits for the most update-to-date information. Please refer to your insurance card for the phone number for Behavioral/Mental Health specifically (Generally listed on the backside of the card).

If using an Employee Assistance Program, please provide the authorization information to your therapist at the beginning of your first visit.

Thank you.

CORNERSTONE COUNSELING CENTER, PC
6011 JONESTOWN ROAD
HARRISBURG, PA 17112

CLIENT INFORMATION SHEET
(Please Print)

Date: _____

Client Name: First: _____ MI _____ Last _____

Date of Birth: ___/___/___ Sex: M F SS#: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Work _____ Cell _____

Circle if okay to leave message: Home Work Cell

E-Mail Address: _____

Employment Status: ___ Full-time ___ Part-time Occupation: _____

Name of Employer: _____

Student: ___ Full-time /Part-time: ___ Grade: _____

Name of School: _____

History of Difficulties with conduct, homework, peers, or authority: _____

Parents (if under the age of 18):

Mother Name: _____ Birthdate: ___/___/___

Address: _____

Phone number: _____ - _____ - _____

Father Name: _____ Birthdate: ___/___/___

Address: _____

Phone Number: _____ - _____ - _____

Emergency Contact: _____ **Relationship:** _____

Phone Numbers: (Home) _____ (Cell) _____

Name of your PCP: _____ Phone No.: _____

Current Medications:

Mental Health Treatment History (please check all that apply)

None: _____ Outpatient: _____ IOP/Day Treatment: _____
In Patient: _____ Self Help: _____

Substance Use/ Abuse History: (please check all that apply)

None: _____ Alcohol: _____ Marijuana: _____
Cocaine: _____ Opiates: _____ Cocaine: _____
Tranquilizers: _____ Hallucinogens: _____

INSURANCE INFORMATION **Please supply your insurance card to be copied**

Insured ID # _____ Policy/Group # _____

Insurance Company: _____

Insured Name: _____ Date of Birth: _____

Insured Social Security Number: _____

Client relationship to insured: Self Spouse Child Other

Employer: _____

SECONDARY INSURANCE If you have secondary insurance, please complete the following:

Insured ID # _____ Policy/Group # _____

Insurance Company: _____

Insured Name: _____ Date of Birth: _____

Patient relationship to insured: Self Spouse Child other

Employer: _____

Consent to use and disclose your Health Information

This form is an agreement between you, _____, and Cornerstone Counseling Center. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at (717)671-9520, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

****I give my consent for services for myself or my child/legal dependent with Cornerstone Counseling Center, P.C. to Include: Evaluation, psychotherapy, testing (if indicated) and involvement in the treatment planning and implementation process****

Signature of Patient (or guardian if patient under age 14)

Relationship to Patient (if signer is other than patient)

Patient's Date of Birth

Signature of Witness

Date

Date

CORNERSTONE COUNSELING CENTER, PC
6011 JONESTOWN ROAD
HARRISBURG, PA 17112
Phone 717-671-9520
Fax 717-671-9524

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name _____ Date of Birth _____

I, _____, by my signature below, do hereby consent and authorize Cornerstone Counseling Center, PC, to disclose to/receive from _____ protected health information from my record(s) related to my identity, diagnosis, prognosis, and/or treatment (including diagnosis and/or treatment for substance abuse). The specific information to be disclosed includes but is not limited to (include dates where appropriate):

_____ Patient Data Form _____ Referral/Summary Letter _____ Complete copy of medical record
_____ Initial Evaluation _____ Psychological/Ed. Evaluation _____ Other _____
_____ Treatment Summary _____ Discharge Summary

I understand that this information is to be used for the purpose of:

[x] BILLING

I understand and agree that this Authorization will be valid and in effect until six (6) months after discharge from treatment unless otherwise specified: _____. I understand that I can revoke this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I further understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I have read this form and understand what it means:

Patient's Signature _____ Date _____

Personal Representative's Signature _____ Date _____

Description of Representative's Authority _____

Witness Signature _____ Date _____

Copy offered: ___ refused ___ accepted

PATIENT CONTRACT

Please read all information 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; 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 of 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, and leave your name and phone number to reach the on-call therapist. 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 \$____150.00____. 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 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 24 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.

*****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 X _____ Date: _____

Cornerstone Counseling Center

INFORMED CONSENT CHECKLIST FOR TELETHERAPY SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.

Confidentiality still applies of therapy 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 your 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 your 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 contract information) for you to participate in tele therapy 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, tele therapy is no longer appropriate and that we should resume our sessions in-person.

Therapist Name / Signature: _____

Patient Name: _____

Signature of Patient/ Patient's Legal Representative: _____

Date: _____

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6011 JONESTOWN ROAD
HARRISBURG, PA 17112

TELEPHONE
(717) 671-9520

FAX
(717) 671-9524

ROBERT J BEACHY, PSY. D
CYNTHIA GALLIHER, L.C.S.W.
MARY DISKERUD, L.C.S.W

FREDERICK E. HENRY, L.C.S.W
JOHN WICKIZER MA, LPC
JANICE NEWCOMER, MS, CAC, LPC

Missed Appointment Policy

Missed appointments and late cancellations at our facility will be charged by the following guidelines:

1st time - \$65

2nd time - \$100

3rd time - \$125

I have read, and understand, the above policy.

Patient/Legal Guardian

Date

Witness

Date