Cornerstone Clinic Counseling Center

Information and Informed Consent

(Please initial on line indication you have read the paragraph) (Rev. 9-20-19)

_____ Introduction: Cornerstone Clinic is committed to treating the whole person. We provide counseling services to nurture you to become a healthy individual in body, soul and spirit. Clinic services are provided by licensed psychologists and master level clinicians, individuals with masters' degrees seeking licensure, and students in graduate programs. The interns and non-licensed clinicians are under supervision with on-site supervisors. If you have questions about your treatment, you may call us at 907-522-7080.

_____ Confidentiality: We place a high value on client privacy; all records are confidential. If cell phones are taken into session, they are not to be used by any person present, including the therapist, without the client's permission. We may bring client cases to case consultation or consult with another therapist within the agency. Should we do so, no name or other identifying information will be shared. You may give written permission for your therapist to share information with other people like medical or psychiatric providers, school personnel, case workers, or family.

Legal requirements specify certain condition in which it is necessary for us to disclose your name and/or your treatment. These requirements are as follows:

1. **If we believe you are a danger to yourself or others**
2. **If we become aware of any involvement you have in the abuse of children, elderly or disabled persons**
3. **If we are ordered by a judge or court to release your records**

_____ Fees:	Initial (90 min)	Follow up (45-50 min)	60 min	60-90 min
Psychologist(s):	$300	$175	$210	$263
Master level clinician:	$280	$150	$180	$225
Unlicensed clinicians With masters degree:	$75	$75	$90	$112
Students in masters Program:	$35	$35	$42	$63

_____ Fees Continued: I understand that if my therapy hour extends over the normally scheduled time, I may be responsible for a larger co-pay and anything my insurance company will not cover. Fees also apply to the preparation of assessment and other reports, telephone conversations, consultations, or meetings you have authorized as part of your counseling process. We will bill your primary carrier as a courtesy if you see a licensed clinician. Insurance co-pays are due at the time of visit**. If insurance does not pay, you are responsible for your bill.** Billing is done through Diversified Health Care Management, Phone number: 907-770-2380

_____ Client Responsibility: If you can't attend a scheduled session, please give us a 24-hour notice of cancellation. After three no-shows or cancellations in a row, you may be subject to termination of services. You will be charged $100 for not keeping an appt/late cancellation if seeing psychologist, $75 for master level, and $35 with a student.

_____ Play Therapy: As a parent or care giver, you will allow your child's sessions to be recorded/video-taped.

_____ Therapist Information: I received information about my therapists' qualifications.

_____ **Consent is herby given to CHA/Cornerstone Clinic to administer appropriate treatment. I also consent to the release of information for insurance purposes from my insurance company to Cornerstone Clinic. This signed consent shall remain in effect until it is revoked by client or guardian, at which time written notice must be given to withdraw existing consent. I am responsible for all charges generated for services rendered including services not covered by my insurance company.**

I have read this document and agree to participate in my treatment under the conditions described above.

Signature: _____ Date: _____

Cornerstone Clinic
Counseling Intake Form

Client Name: _____
First MI Last
Mailing Address: _____

Res. Address: _____

_____
City State Zip Code

To respect your privacy, we need a confidential phone number: _____
Work Phone: _____ Home Phone: _____ Cell: _____
E-Mail Address (Optional): _____
SSN: _____ Birthdate: _____
Emergency Contact/Phone number: _____

Gender: ■Male ☐Female
Employer: _____ Occupation: _____

How did you hear about us? _____

Family History
Your birth order (circle): ■1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 Other: _____
Were there any adoptions in your family? Explain: _____

Marital Status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced
☐Single w/ Children ☐Married w/ Children ☐Widowed
Are you living with your spouse/partner? ☐Yes ■No
Ages of your children: _____ _____ _____ _____ _____ _____ _____
Church attended if applicable: _____
Primary language: _____
Special needs: _____
Race/Ethnicity: _____

Insurance Information
Subscriber Name: _____ DOB: _____
Relationship to Client: _____
Insurance Co.: _____ Address: _____
_____
800 #: _____ Your ID #: _____
Group ID #: _____ Other Info: _____

In order to process your insurance claims more efficiently, we need a copy of your insurance card.
Please give your card to the front desk receptionist for copying.
To the best of my knowledge, this information is true.

Signature: _____ Date: _____
(rev 9-19-13)

Counseling/Medical History

Have you previously sought counseling? ■Yes ☐No

If yes, please explain: _____

Psychiatrist (if applicable): _____

Medical History: _____

_____

Primary Care Physician: _____

Current Health Status: ☐Excellent ☐Good ☐Fair ☐Poor

How long has it been since your last physical exam? _____

Current Medications: _____

Chemical Use

History: ■Yes ☐No Current: ■Yes ☐No

Substances: _____

Frequency: _____

Amount: _____

Longest period of sobriety: _____ Length of use: _____

Prior Treatment: _____

_____

Rate the items with which you are currently having problems.
Choose the number that best indicates the existence or severity of the problem.
0=None 1=Minor 2=Moderate 3=Significant 4=Serious
Choose the word(s) in brackets that best define(s) each statement.

Anxiety: ☐[Worry] ☐[Fear] ☐[Panic] ☐[Phobia]	■0 ☐1 ☐2 ☐3 ☐4
Feelings of: ☐[Depression] ☐[Sadness]	■0 ☐1 ☐2 ☐3 ☐4
Thoughts of: ☐[Death] ☐[Suicide]	■0 ☐1 ☐2 ☐3 ☐4
Sleep Disturbance:	■0 ☐1 ☐2 ☐3 ☐4
Mood Swings:	■0 ☐1 ☐2 ☐3 ☐4
Grief over: ☐[Death of Loved One] ☐[Major Loss]	■0 ☐1 ☐2 ☐3 ☐4
Issues Related to: ☐[Pregnancy] ☐[Abortion]	■0 ☐1 ☐2 ☐3 ☐4
Abuse: ☐[Physical] ☐[Domestic] ☐[Emotional] ☐[Ritual]	■0 ☐1 ☐2 ☐3 ☐4
Sexual Abuse: ☐[Incest] ☐[Rape]	■0 ☐1 ☐2 ☐3 ☐4
Parent(s) had Problems with: ☐[Alcohol] ☐[Drug]	■0 ☐1 ☐2 ☐3 ☐4
Marriage Problems:	■0 ☐1 ☐2 ☐3 ☐4
Relationship Problems with Children:	■0 ☐1 ☐2 ☐3 ☐4
Problems with: ☐[Parents] ☐[Family]	■0 ☐1 ☐2 ☐3 ☐4
Problems with: ☐[Work] ☐[School] ☐[Legal]	■0 ☐1 ☐2 ☐3 ☐4
Sexual: ☐[Concerns] ☐[Problems]	■0 ☐1 ☐2 ☐3 ☐4
Problems with: ☐[Alcohol] ☐[Drugs] ☐[Smoking] ☐[Other:_____]	■0 ☐1 ☐2 ☐3 ☐4
Feelings of: ☐[Hopelessness] ☐[Helplessness] ☐[Despair]	■0 ☐1 ☐2 ☐3 ☐4
Memory: ☐[Forgetfulness] ☐[Changes]	■0 ☐1 ☐2 ☐3 ☐4

Have you ever felt people were watching you?	☐Yes	■No
Do you hear voices?	☐Yes	■No
Do faces ever seem distorted?	☐Yes	■No
Do colors ever seem too bright or too dull?	☐Yes	■No
Have you ever attempted suicide?	☐Yes	■No

In your own words, state the concerns that bring you to counseling: _____

_____

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   ☐Yes ■No If yes enter 1 _____

2. Did a parent or other adult in the household **often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   ☐Yes ■No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   ☐Yes ■No If yes enter 1 _____

4. Did you **often** feel that…
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   ☐Yes ■No If yes enter 1 _____

5. Did you **often** feel that…
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ☐Yes ■No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   ☐Yes ■No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   ☐Yes ■No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ☐Yes ■No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   ☐Yes ■No If yes enter 1 _____

10. Did a household member go to prison?
    ☐Yes ■No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Extended Confidentiality

(Rev. 10-7-19)

It has come to our attention that there may be people whom you (our client) may allow to make or cancel an appointment for you.

Ethics surrounding confidentiality state that without your permission, we can neither verify nor deny you are a client of Cornerstone Counseling Center. This standard holds true even if you are seen as part of a couple; we would not give your parent/spouse/partner/ friend any information regarding your treatment at Cornerstone Counseling Center, nor allow them to make, verify, or cancel an appointment without your permission.

I give the following people access to:

_____ Billing Information

_____ Client Records

_____ Appointment Scheduling or Canceling

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Client Name: _____ Date: _____

This policy will stay in effect until you inform us otherwise!

Cornerstone Clinic Counseling Center
(Rev. 4-6-20)

Informed Consent for Telehealth Services

Definition of Telehealth:

Telehealth or telemental health is the practice of delivering clinical health care service to counseling clients using interactive video and/or audio communications.

I, _____, hereby consent to participate in telemental health with

_____ as part of my psychotherapy. Date: _____

The same laws that apply in face-to-face counseling also apply in telemental health. In other words, everything in the telemental health session remains confidential unless:

a. The client learns of child, elder or handicapped persons abuse
b. In the case of threatened homicide or suicide
c. Ordered by a judge or court to release records

I understand the following with respect to telemental health:

A. Cornerstone Counseling Clinic will utilize technology that is HIPAA compliant as far as it is able. As the client, you have the responsibility to secure a safe, confidential setting for yourself.

B. You have the right to withdraw consent at any time without affecting your right to future care or services. You or the counselor may find that telemental health isn't well-suited to you and therefore you and your counselor will discuss alternatives.

C. You need to understand there are risks, benefits and consequences associated with telemental health, including potential disruption of transmission by technology failures. Interruption and/or breaches of confidentiality by unauthorized persons and/or limited ability to respond to emergencies.

D. There will be no recording of any of the online sessions by either party. Written records are confidential and will not be disclosed to anyone without written authorization unless required by law.

E. Services will be billed through our billing company as are face to face visits. If for some reason your insurance company will not pay for telemental health services, you will be responsible for your bill. Before you are scheduled for a telemental health visit, please make these arrangements with our front desk at 907-522-7080.

F. You understand that your therapist may need to contact your emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

Your counselor needs to know your location in case of an emergency. You agree to inform us of the address where you are at the beginning of each session. We also need a contact person who we may contact on your behalf in case of a life-threatening emergency only.

In case of an emergency, my location is: _____

And my emergency contact person is: _____

Emergency contact address: _____

Emergency contact phone number: _____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of Therapist Date

Please Note: When you click the email form button below, it will create an email for you in your draft folder.

EMAIL FORM