Cornerstone
Psychological Services, PA

2711-A Pinedale Road,
Greensboro, NC 27408
[P] 336 540-9400 [F] 336 540-9454
www.CornerstoneHelps.com

Psychotherapy • Psychological Assessments • Consultation
Employee Assistance Programs

Client Information: CHILD/ADOLESCENT Therapist: _____

Please print clearly Record # _____

MC# _____

Who referred you to Cornerstone? _____

The kind of custody I have of the minor named below is:

_____ Legal Custody (e.g., natural, adoptive or foster parent with legal right to authorize psychological services)

_____ Legal Authority (e.g., social services representative with legal right to authorize psychological services)

If Legal Authority, who has Legal Custody of the minor? _____

Admission (initial appointment) Date: _____ Discharge Date: _____

Name: _____ Age: _____ Sex: M F Race: _____

Address : _____ _____ _____ _____

Street or Box Number City State Zip Code

Child's Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Status of Parent: Single_____ Married_____ Partnered _____ Separated_____ Divorced_____ Widowed_____

Telephone Number That is Best to **Contact Parent/Caregiver: _____**

Father's Name: _____ Age: _____ Home Ph: _____ Mobile Ph _____

Email: _____

Mother's Name: _____ Age: _____ Home Ph: _____ Mobile Ph _____

Email: _____

Occupation: Father Employed By: _____ Work Phone: _____

Mother Employed By: _____ Work Phone: _____

Other Caregiver: _____ Relationship: _____

Social Security Number of Child: _____

Social Security Number of Parent Responsible For Payment: _____

In Case of Emergency Contact: _____ Phone: _____

Address: _____

Please present your insurance card (and the card for secondary insurance if you have it) to your therapist so a copy may be placed in your record.

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CLIENT NAME: _____ MC ID #: _____ Record # _____

CONSENT FOR TREATMENT

I freely give my consent for psychological/counseling services to be provided by the staff of Cornerstone Psychological Services. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the therapist. I am aware that I may stop treatment at any time, though understand that doing so may be therapeutically premature or that I may have to deal with other problems (legal, for example, if treatment is court ordered).

FINANCIAL RESPONSIBILITY

I accept responsibility for payment of services rendered by Cornerstone Psychological Services. I agree to make a full payment or a co-payment, if insurance coverage is available, at the time services are provided.

Cornerstone Psychological Services is not responsible for determining or verifying insurance coverage. I understand and accept that it is my responsibility to determine my insurance coverage and to get any pre-authorizations required. Because Cornerstone may not be aware of other professionals involved in my care, it is also my responsibility to keep track of the total number of mental health sessions used here and elsewhere, and to tell my therapist of insurance limitations.

I further understand that my insurance may not cover all sessions and activities that I may be billed for, and accept responsibility for payment for services that are not covered and/or not reimbursed (for example, exceeding the number of authorized sessions, denied sessions, psychological evaluations, couples counseling, telephone consultations, letters and reports).

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. I accept that if I do not cancel and do not show up I will be charged for that appointment at up to the therapist's full fee and understand that it cannot be billed to insurance. If seen through an Employee Assistance Program, I know a late cancellation or missed appointment may count as one of my sessions.

I authorize release of information acquired in the course of examination and treatment to my insurance company and assign payment of fees directly to Cornerstone Psychological Services.

If I don't pay as agreed in accordance to the above conditions, I accept that my account may be turned over to a collection agency and that all collection costs associated with the debt will be my responsibility.

ELECTRONIC LIMITATIONS

There may be at times a need to communicate via electronic means (e.g., cell phone, email, text, fax, client portal, video-chat). Cornerstone uses a password protected and encrypted web based calendar for scheduling. Cornerstone Psychological Services exercises all reasonable precautions to protect confidentiality but cannot guarantee confidentiality of such electronic and web-based systems as some difficulties are beyond our control.

My signature below indicates that I have received or downloaded the Emergency Procedures form.

My signature below shows that I have carefully read, understand and agree with all of these statements.

_____ _____

Parent or Legal Guardian Signature Date

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NAME: _____ MC#: _____ Record #:

_____

Cornerstone Psychological Services is sensitive to your privacy and the confidentiality of services. However, for rescheduling or appointment confirmation purposes, it may occasionally be necessary for our office to contact you.

Please let us know the best way to reach you:

Cell: _____ May we leave a message? Yes No

Home: _____ May we leave a message? Yes No

Work: _____ May we leave a message? Yes No

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John L. Holt, MA, LPA, LPC
Robert Harmon, MA, LPA
Joy Farlow, MA, LCSW
Debi Pruitt, MA, LPCA
Randy Readling, MD

CONSENT FOR RELEASE OF INFORMATION TO YOUR PRIMARY CARE PHYSICIAN AND PSYCHIATRIST

CLIENT: _____ Record #_____

DOB: _____

Your (or your child's) primary care doctor and your psychiatrist (if you are seeing one) are interested in knowing if you are being seen for counseling. Having this information helps them to better serve your health care needs and is consistent with best practices.

_____ I authorize my Cornerstone therapist to release relevant treatment information, such as history, symptoms and diagnostic impression, and alcohol and/or drug use if relevant, to my/my child's primary care doctor and psychiatrist for coordination of treatment and continuity of care. I also authorize my/my child's primary care doctor and psychiatrist to release relevant information to my Cornerstone therapist. I understand that these records are confidential and cannot be released without written authorization except as provided by law. This consent may be revoked at any time and expires one year from the date signed.

Primary Care Physician: _____

Psychiatrist: _____

_____ I decline the release of treatment information to my/my child's primary care physician and psychiatrist.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid for a period not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that action on this consent has been taken. In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

CLIENT: _____ OR _____
Parent, Guardian or Legal Representative

Cornerstone Psychological Services, PA

Patient Consent Form and Confidentiality

Client Name: _____ MC#: _____ Record #:_____

By signing this form, you grant consent to Cornerstone Psychological Services, PA the right to use and disclose your protected health information for the purposes of treatment, payment and health care operations (TPO) subject to our Privacy Policy and as they may change from time to time. The following is a summary of our Privacy Policy. A complete copy is available as outlined below.

Cornerstone Psychological Services, PA has developed a Privacy Policy to address the following:

- We will use and disclose your health care information for the purposes of treatment, payment, and to support other related, defined health care operations.
- We will keep your health care information confidential, releasing it only according to our policies. In general, we will release your information to others only if we are referring you for care, or if you direct us to do so. However, there are exceptions to that general limitation. (An example would be a release of information that is required by State or Federal law.)
- You have the right to request to inspect and copy the health care information we keep regarding you, or regarding someone for whom you are the guardian. In some cases, we may refuse to permit you to do so. For example, if we determined that doing so might cause you or another person harm.
- You have the right to request that we amend the health care information we keep regarding you, or regarding someone for whom you are the guardian.
- You have the right to request a list of non-routine disclosures to other parties we have made of your health care information, or that of someone for whom you are a guardian.
- You have the right to request a limit to the type and amount of health care information that we disclose. We are not required to accept that limit, if it affects our ability to engage in TPO, for example. If we do honor the limit request we will be bound by that agreement.
- You have the right to request specific confidential communications that further restrict the parties who will have access to your information, though in general, we will not disclose personal health care information except as described above. Again, we are not required to agree to that limitation but, if we do so, we will be bound by that agreement.
- When a child is in treatment and the parents are divorced, and the parents have joint custody, the N.C. Attorney General's Office has advised us that as psychotherapists, we are obligated to inform both parents that the child is in treatment and the nature and course of treatment.
- If a therapist suspects that child abuse or neglect has occurred, the law requires that it be reported to the proper authorities.
- If a therapist believes you to be a clear and imminent danger to yourself or another person, she or he must take steps to prevent that occurrence. These steps may require breaking confidentiality.
- In a legal proceeding, client-therapist communications are privileged. A judge can, however, order the therapist to divulge confidential information if this information is deemed necessary for the proper administration of justice. There is one exclusion; N.C. law provides that a marriage counselor is incompetent to testify in any subsequent legal action regarding divorce.
- Your records can be released without your consent to prove to the appropriate agencies that Cornerstone Psychological Services, P.A. is in compliance with federally mandated HIPAA privacy laws.
- Your records can be released without your consent upon request from the military for purposes of national security.

Our Privacy Policy is subject to change from time to time. If we change our policy, you may obtain a copy of the revised notice by contacting us in our Greensboro office or by calling (336) 540-9400.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent previously granted.

Signature:_____Date: _____

Client/Legal Guardian

CLIENT NAME: _____ MC ID #: _____ Record # _____

Credit Card Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.

I, _____, hereby authorize Cornerstone Psychological Services, PA to use my credit card information to charge my credit card under the following conditions:

- Missed appointments ($50 then $75 thereafter)
- Cancellations with less than 24 hours notice ($50 then $75 thereafter)
- If a check is returned for any reason (plus bank charges)
- Balances of charges not paid by me or my insurance
- Fees not covered by insurance
- Insurance payments made to me rather than to Cornerstone Psychological Services
- Miscellaneous other fees (e.g., court preparation/testimony, disability preparation, letters/reports, etc.)

Type of Card: VISA MasterCard Discover

Card Number: _____-_____-_____-_____

Exp. Date: _____/_____

Verification/Security Code: _____

Billing Address Zip Code: _____

Billing Address Street Number: _____

I may revoke this agreement at any time by providing a written request.

_____ _____

Client (or parent/guardian) Signature Date