skills support hope
CORNERSTONE

Thank you for choosing Cornerstone as your care provider. We understand that completing forms is a tedious process. Therefore, we have made every effort to simplify our forms by asking only for the information we need. We appreciate your time in accurately completing this form. Please keep in mind that your confidentiality is assured. The information you provide is protected by law and will not be released without your written authorization. If you have any questions about this form, please discuss them with your provider.

Part 1: Client Registration

CLIENT LAST NAME FIRST MIDDLE INITIAL			HOME TELEPHONE	CELL PHONE
HOME ADDRESS			CITY	STATE ZIP COUNTY
GENDER	AGE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	EMAIL ADDRESS
EMPLOYER			CITY	STATE ZIP

MAY WE CALL AND/OR LEAVE A MESSAGE FOR YOU AT	SHIFT
☐ HOME ☐ WORK ☐ CELL ☐ ALL ☐ EMAIL ☐ NONE	☐ AM ☐ PM ☐ NIGHT ☐ WEEKEND ☐ NA

SPOUSE/PARTNER LAST NAME FIRST MIDDLE INITIAL	DATE OF BIRTH
ADDRESS (IF DIFFERENT) HOME PHONE	CELL PHONE

PARENT/LEGAL GUARDIAN (IF CLIENT IS MINOR)			ADDRESS (IF DIFFERENT)
HOME PHONE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	EMPLOYER
EMERGENCY CONTACT		RELATIONSHIP	PHONE NUMBER

Part 2: Concerns

WHY ARE YOU SEEKING COUNSELING AT THIS TIME?

- ☐ ADOPTION ISSUES
- ☐ ANGER MANAGEMENT
- ☐ ANXIETY/STRESS
- ☐ BEHAVIORAL PROBLEMS
- ☐ DEPRESSION
- ☐ GRIEF/LOSS
- ☐ HYPERACTIVITY/IMPULSIVITY
- ☐ RELATIONSHIP ISSUES
- ☐ SELF-ESTEEM
- ☐ WORK-RELATED ISSUES
- ☐ OTHER (PLEASE EXPLAIN) _____

_____

_____

IF SOMEONE REFERRED YOU TO CORNERSTONE, PLEASE TELL US WHO? _____

Continue on next page

Part 3: Service Fee Agreement

Payment is due at the time services are rendered unless other arrangements have been made. Cornerstone makes every reasonable effort to obtain benefit information from insurance companies. However, information quoted by insurance companies is no guarantee of payment. Therefore, you must understand that it is sole responsibility of the client or parent/guardian, not the insurance company, to pay for any and all services provided by Cornerstone. Cornerstone files insurance claims as a courtesy. Co-payments are due at the time services are rendered.

Your appointment times are reserved for you. If you are unable to keep your appointment, please notify our office 24 hours in advance. You may be charged for missed appointments at the discretion of your care provider. Insurance companies will not pay for missed appointments. We reserve the right not to reschedule clients who repeatedly fail to keep appointments.

I affirm that I have read, understood and agree to abide by this fee policy. By my signature below, I acknowledge that I am the party responsible for payment and accept the agreement above. I also understand and acknowledge that I am personally responsible to pay Cornerstone in full for services that my health insurer will not cover due to non-payment of my health insurance premiums."

_____ _____

SIGNATURE OF CLIENT/PARENT/GUARDIAN CLIENT NAME

_____

DATE

Part 4: Insurance Information

PRIMARY INSURANCE (PLEASE ALLOW RECEPTIONIST TO PHOTOCOPY YOUR INSURANCE ID CARD)

PLAN NAME		INSURED'S NAME (IF OTHER THAN CLIENT)
INSURED SOCIAL SECURITY NUMBER		INSURED'S DATE OF BIRTH
POLICY/ID NUMBER	GROUP NUMBER	EFFECTIVE DATE
CLAIMS ADDRESS AND PHONE		
DEDUCTIBLE	CO-PAY	VERIFIED INITIAL & DATE

SECONDARY INSURANCE (PLEASE ALLOW RECEPTIONIST TO PHOTOCOPY YOUR INSURANCE ID CARD)

PLAN NAME		INSURED'S NAME (IF OTHER THAN CLIENT)
INSURED SOCIAL SECURITY NUMBER		INSURED'S DATE OF BIRTH
POLICY/ID NUMBER	GROUP NUMBER	EFFECTIVE DATE
CLAIMS ADDRESS AND PHONE		

Cornerstone receives funding from a variety of sources. Some funding sources, including the United Way of Adams County, ask us for demographic information related to the people we serve. No personally identifiable information is ever shared with any funding source except your insurance company if applicable or as described in our Notice of Privacy Practices.

Completion of this form is voluntary. Your decision to provide the information will not affect your treatment. If you are participating in a United Way funded program, your responses are required.

TOTAL NUMBER OF PEOPLE IN YOUR HOUSEHOLD _______________ (PLEASE LIST BELOW OTHERS NOT LISTED ON PAGE 1)

NAME	DATE OF BIRTH	GENDER	RACE
______________________________	_______________	________	☐ AFRICAN AMER/BLACK ☐ WHITE ☐ HISPANIC ☐ BIRACIAL ☐ OTHER
______________________________	_______________	________	☐ AFRICAN AMER/BLACK ☐ WHITE ☐ HISPANIC ☐ BIRACIAL ☐ OTHER
______________________________	_______________	________	☐ AFRICAN AMER/BLACK ☐ WHITE ☐ HISPANIC ☐ BIRACIAL ☐ OTHER
______________________________	_______________	________	☐ AFRICAN AMER/BLACK ☐ WHITE ☐ HISPANIC ☐ BIRACIAL ☐ OTHER
______________________________	_______________	________	☐ AFRICAN AMER/BLACK ☐ WHITE ☐ HISPANIC ☐ BIRACIAL ☐ OTHER
______________________________	_______________	________	☐ AFRICAN AMER/BLACK ☐ WHITE ☐ HISPANIC ☐ BIRACIAL ☐ OTHER

WILL ANY OF THESE HOUSEHOLD MEMBERS BE INVOLVED WITH TREATMENT ☐ YES ☐ NO ☐ UNCERTAIN

PLEASE RESPOND TO THE FOLLOWING FOR THE PERSON LISTED AS CLIENT ON PAGE 1

MARITAL STATUS	EDUCATION	EMPLOYMENT	HOUSING
☐ SINGLE	☐ K THRU 8TH	☐ FULL-TIME	☐ OWN/FAMILY HOME
☐ MARRIED	☐ SOME HIGH SCHOOL	☐ PART-TIME	☐ RENT/LEASE
☐ SEPARATED	☐ HIGH SCHOOL GRAD	☐ RETIRED	☐ GROUP QUARTERS
☐ DIVORCED	☐ VOCATIONAL SCHOOL	☐ HOMEMAKER	☐ SHELTER
☐ WIDOWED	☐ SOME COLLEGE	☐ UNEMPLOYED-LONG TERM	☐ HOMELESS
	☐ 2 YR COLLEGE DEGREE	☐ UNEMPLOYED-SEASONAL	☐ OTHER
	☐ 4 YR COLLEGE DEGREE	☐ STUDENT	
	☐ GRAD DEGREE		
	☐ DOCTORATE		

IF THE PERSON LISTED AS THE CLIENT ON PAGE 1 IS A CHILD, PLEASE RESPOND TO THE FOLLOWING FOR THE HOUSEHOLD IN WHICH THE CHILD LIVES

HEALTH INSURANCE		INCOME (SEE TABLE)	FEDERAL POVERTY GUIDELINES
☐ PRIVATE		☐ ABOVE POVERTY LEVEL	FAMILY SIZE ANNUAL INCOME
☐ PUBLIC (MEDICAID)		☐ BELOW POVERTY LEVEL	1 $11,770
☐ NONE			2 $15,930
			3 $20,090
			4 $24,250
			5 $28,410
			6 $32,570
			7 $36,730
			8 $40,890

THANK YOU FOR YOUR COOPERATION IN COMPLETING THIS FORM!

FOR USE BY CORNERSTONE STAFF

PROGRAM _______________ ID NUMBER ___________________ STAFF MEMBER ___________________

Cornerstone Foundations for Families
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 REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the codes of ethics for our professions. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As licensed clinicians this state, it is our practice to adhere to more stringent privacy requirements as dictated by the standards of practice and code of ethics of our profession for disclosures without an authorization. The following language addresses these categories to the extent consistent with these ethical codes and HIPAA.

Child or Elder Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Chris Parker, MS Ed., LCPC, NCC, Cornerstone Foundations for Families, 915 Vermont, Quincy, IL 62301.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer identified above if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the

request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.
- **Choose Someone to Act for You.** If you have given someone medical power of attorney or if someone is your legal guardian that person can exercise your rights and make choices about your health care. We will make sure the person has this authority and can act for you before we take any action.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer Chris Parker, MS Ed., LCPC, NCC or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (877) 696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you for filing a complaint.

The effective date of this Notice is September 23, 2013.

Cornerstone: Foundations for Families
Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name:_____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Cornerstone Foundations for Families Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I may ask my service provider or contact Cornerstone's Privacy Officer Chris Parker MS Ed., LCPC, NCC, 915 Vermont, Quincy, IL 62301 or by calling 217-222-8254

_____ _____
Signature of Client Date

_____ _____
Signature or Parent, Guardian or Personal Representative * Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Client Refused to Acknowledge Receipt**

☐ **Notice of Privacy Practices provided after services began due to need for crisis intervention.**

_____ _____
Signature of Staff Member Date

CORNERSTONE
CLIENT RIGHTS AND CONSENT TO SERVICES

Client: _____ Client: _____

YOUR RIGHTS AS A CLIENT OF CORNERSTONE

Please review the information below and let your service provider know if you have any questions. We are committed to working with you to achieve your goals.

- To make the most progress as quickly as possible, we invite you to:
  - Identify the main concerns you want to work on.
  - Monitor your progress toward goals.
  - Keep us informed of whether our partnership is on track.
- Our relationship with you and your family is confidential. The only times we can disclose information are under the following circumstances:
  - In situations where we are court ordered to do so.
  - In situations where someone is in danger and appropriate safety action must be taken.
  - In situations where child or elder abuse or neglect is suspected.
- The records we keep are available for you to see. Please talk with your therapist or case manager if you would like to review your records. We believe that working together produces the best results for you.
- You will not be discriminated against with regard to your age, sex, race, religion, marital status, national origin, or disability.
- You can refuse or terminate services at any time, and we will do our best to explain any consequences which could result from a refusal of services.
- If at any time you are not happy with the services you are receiving, please talk it over with your therapist, case manager, or the Clinical Supervisor.
- We will not deny, suspend, or terminate services due to exercising any of these rights.

CONSENT TO SERVICES AND ACKNOWLEDGMENT OF RIGHTS

I hereby consent to receive counseling, rehabilitative mental health, or psychiatric services at Cornerstone. I have reviewed a copy of this notice of my rights. I have had a chance to have my questions answered about my rights.

I further acknowledge receipt of Cornerstone's Notice of Privacy Practices on the date below.

_____ _____
Client (age 12 and over) Date

_____ _____
Parent/Legal Guardian Date

_____ _____
Other Participant in Treatment Date

_____ _____
Witness Date

skills
support
hope
CORNERSTONE

Counseling Services
Fee Policy

Effective

August 2015

www.cornerstone-quincy.org

Thank you for choosing Cornerstone for your mental health care. Your satisfaction is important to us. Our goal is to provide you the highest quality counseling services. *You matter.*

Cornerstone is a not-for-profit community organization. We obtain funding for our counseling services through various sources including insurance plans, Employee Assistance Programs, private fees, and the United Way of Adams County.

Current Fees

The initial visit is $200.00. Thereafter, the fee is based on the complexity of your visit and the services provided. The cost may range from $112.00 to $150.00 per visit.

United Way of Adams County provides some funding to Cornerstone to assist individuals and families without health insurance or other means to pay for the cost of care. Eligibility for this assistance is based on household income and family size. We do have a minimum fee, as it is our experience that this fosters increased investment in counseling. Our business office staff will discuss your particular situation at your initial appointment.

Payment

Our business office staff will meet with you at your initial visit to collect information concerning your medical insurance coverage and verify co-pay and deductible amounts. We ask that you arrive early for the initial visit to allow sufficient time for staff to meet with you.

At the initial visit, you will be asked to sign a fee agreement. This agreement specifies the amount you are responsible to pay at each visit.

We require that you pay all amounts for which you are responsible at the time services are provided. This enables us to keep the cost of your care as low as possible.

We bill your insurance company as a courtesy to you. However, please remember that our treatment and financial arrangements are with you, not your insurance company.

Please notify our office immediately if your insurance company changes.

When our agency submits a claim to your insurance carrier, the following information will appear on the claim form: the name and address of the insured and name and address of the person receiving service; Social Security Number, group and/or individual policy ID number; diagnosis, and dates services were provided, and fees charged. This information will be available for filing to your insurance provider for up to one year following the date services are terminated.

Other information

Cancellations/Missed Appointments: If you do not notify the agency at least twenty-four (24) hours prior to your appointment time, you will be charged your designated fee for the missed visit. Insurance will not cover the cost for missed appointments.

Delinquent Accounts: If your account becomes more than 30 days overdue, Cornerstone reserves the option to deny scheduling future appointments until the account is paid in full. If your account becomes 60 days overdue, Cornerstone will refer you to a collection agency and will not schedule future appointments. If it is necessary to refer to a collection agency, you will be responsible for all costs associated with collection fees.

Fee Review: Cornerstone's policy requires a review of our fee structure at least on an annual basis. You will be notified before any changes are made to your designated fee.

Medicaid/Medicare: Cornerstone does not accept Medicaid. Our therapists and nurse practitioner have limited hours available for Medicare beneficiaries. Please discuss your coverage with our business office staff.

Please contact the business office if you have questions regarding fees, or you have changes in your health insurance plan.

For your convenience, we accept Visa, MasterCard and Discover.

If there is anything about your experience at Cornerstone that disappoints you, please contact us immediately so that we may have the opportunity to correct the problem.

Kim Parrish
Business Manager

915 Vermont
Quincy IL 62301
Phone: 217-222-8254
Fax: 217-222-4512

www.cornerstone-quincy.org