



Consent to Screen, Evaluate And/Or Treatment of Services

Patient Name: _____ Date of Birth: _____

Address: _____

Patient's Primary Care Doctor: _____

Primary Care Doctor Phone Number: _____

Patient Diagnosis Code (office use only): _____

- Speech Therapy
- Occupational Therapy
- ABA Therapy

Insurance Information

Primary Insurance: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Phone Number: _____

I authorize Cornerstone Behavioral Health and Pediatric Therapies to screen, evaluate, and provide any subsequent treatment needed based on the evaluation results for the above named child.

Guardian Signature: _____ Date: _____

Guardian Printed Name: _____ Date: _____

Relationship to Patient : Parent Legal Guardian Other: _____

Signature of Cornerstone Representative: _____ Date: _____

Occupational Therapy & Speech Therapy Intake

The information you provide will help our staff determine the care you need and the tests administered during your child's evaluation. A child's individual background, cultural experience, and family support are important factors in determining a treatment plan for your child.

Service Location Preference

Edmond Clinic

Midwest City Clinic

General Information

Child's Name: _____

Birthday: ____ / ____ / ____

Sex: Male Female

Guardian Name: _____

Phone Number: _____

Home Address: _____

City: _____ Zip: _____

Email: _____

Occupation(s): _____

Secondary Caregiver/Guardian Name: _____

Phone Number: _____

Home Address: _____

City: _____ Zip: _____

Email: _____

Occupation(s): _____

Primary Care Physician Name: _____

Primary Care Physician Phone Number: _____

Does your child have a caregiver outside the home? Yes No If yes, describe: _____

School/Daycare Name (if applicable): _____

School District: _____

Current Grade: _____

Does your child have an IEP/504 at school? Yes No

What services, if any, does your child receive at school? _____

Has your child received any other evaluation or therapy (physical, counseling, OT, speech, vision, etc)?

Yes No If yes, describe: _____

Child lives with:

- | | |
|---|---|
| <input type="checkbox"/> Birth Parents | <input type="checkbox"/> Parent and Step Parent |
| <input type="checkbox"/> Adoptive Parents | <input type="checkbox"/> One Parent |
| <input type="checkbox"/> Foster Parents | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Shared Custody (2 homes) | |

List siblings and/or anyone else living in the home:

Name	Age	Relationship

List other languages spoken in the home: _____

Does the child speak the language? Yes No

Does the child understand the language? Yes No

What is the preferred language of the child? _____

What are some of your child's favorite things (activities, foods and/or shows)?:

What activities does your child participate in regularly (ie. soccer, gymnastics, swimming, church)?

Is there anything about your culture or religion we should know that may impact therapy or activities chosen for therapy (ie. holidays, foods, etc)?

Has your child been exposed to trauma related to abuse, neglect, loss of a loved one, divorce, etc.? If so, please explain:

Family Concerns

What do you see as your child's most difficult problem in the home?

What do you see as your child's most difficult problem in school?

Please describe what you want your child to achieve with the help of therapy. (What would you like your child to do that he/she can't do now?)

Medical Background

Pregnancy and Birth History:

Were there any complications during pregnancy with your child? Yes No

Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Cigarette use |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Preeclampsia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Substance use |
| <input type="checkbox"/> Preterm labor | <input type="checkbox"/> Preterm delivery |
| <input type="checkbox"/> Other _____ | |

Were there any complications of the birth/delivery of this child? Yes No

Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Fetal distress | <input type="checkbox"/> Failure to thrive |
| <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Genetic condition _____ |
| <input type="checkbox"/> Other _____ | |

Gestational age at time of delivery: _____

What type of delivery? Vaginal Cesarean Section

Birth Weight: _____

Was your child in the NICU? Check all that apply: Yes No

If so, how long? _____

Please describe any complications that occurred during NICU hospitalization:

This child was: breastfed bottle fed tube fed (Please describe: _____)

Did/does your child have tongue or lip ties? Yes No

If yes, were they corrected and when? _____

Were there any additional complications during your child's first year of life? Yes No

If so, please describe: _____

Which of the following does your child experience?

Condition	Yes	No	If yes, describe:
Frequent colds/respiratory illness			
Frequent strep infections			
Frequent ear infections			
Birth defect/genetic disorder			
Allergies/asthma			
Heart condition			
Vision problem			
Neurological disorder			

Condition	Yes	No	If yes, describe:
Seizures			
Hearing loss			
Head injury			
Hospitalizations			
Skin disorders/eczema			
Fractures bones			
Constipation/diarrhea problems			
Other health condition:			

List current medications your child is taking (please include over the counter medications):

Is your child allergic to any foods? Yes No

If so, what foods? _____

What type of reaction? _____

Is your child allergic to any medications? Yes No

If so, what medications? _____

What type of reaction? _____

Developmental History:

Please indicate the age when your child first performed each of the following INDEPENDENTLY. (It is okay to list an approximate age.) If your child has not yet achieved the milestone, write NA in the age column.

Milestone	Early	On Time	Late	If late, what age?
First words/labeled objects				
Used simple questions				
Followed simple 1 step directions				
Said 2-3 word phrases				
Lifted head when on tummy				
Rolled over				
Sat unsupported				
Crawled on hands/knees				
Stood alone				
Walked independently				

Please check the tasks your child can do independently at this time:

Drink from: bottle spouted cup straw regular cup blows out candles

Feed self: finger feeds eats with spoon eats with fork cuts with knife

Brush teeth: tolerates parent attempts to brush brushes independently

Undressing: shirt pants underwear socks shoes

Dressing: shirt pants underwear socks shoes

Shoelaces: ties shoelaces fastens Velcro shoes

Buttons: opens large buttons opens small dress shirt buttons fastens small buttons
 opens pants button

Zippers: pulls down to open pulls up once pin is placed by adult places pin and pulls up

Bladder: trained days trained nights bowel trained bed wetting

Sleeping: sleeps all night wakes up frequently needs special routine (explain: _____)

Behavior

Please check any of the following that apply to your child:

- | | | |
|--|---|---|
| <input type="checkbox"/> sensitive to sounds | <input type="checkbox"/> mouths objects (after 2) | <input type="checkbox"/> craves jumping/crashing |
| <input type="checkbox"/> dislikes hair brushing | <input type="checkbox"/> is always "on the go" | <input type="checkbox"/> avoids touch from others |
| <input type="checkbox"/> clumsy | <input type="checkbox"/> poor attention | <input type="checkbox"/> dislikes brushing teeth |
| <input type="checkbox"/> weak muscles | <input type="checkbox"/> trouble with transitions | <input type="checkbox"/> prefers routine |
| <input type="checkbox"/> picky eater | <input type="checkbox"/> dislikes playgrounds | <input type="checkbox"/> self injurious behavior |
| <input type="checkbox"/> impulsive/easily frustrated | <input type="checkbox"/> prefers playing alone | <input type="checkbox"/> messy Eater |
| <input type="checkbox"/> avoids entire food categories (all fruits, all meats, etc.) | | |

Family Stressors

Stressor	Yes	No	Explanation, if yes:
Marital separation/divorce			
Death in family			
Financial crisis			
Job change			
School problems			
Legal problems			
Medical problems			
Extended separation from parents			
Other stressful event			
Past or current trauma/history of abuse			

Speech-Language-Hearing History

Do you feel your child has a speech problem? Yes No

If yes, please describe: _____

Do you feel your child has a hearing problem? Yes No

If yes, please describe: _____

Has your child ever had a speech evaluation or screening? Yes No

If yes, where and when _____

What were the results? _____

Has your child ever had a hearing evaluation or screening? Yes No

If yes, where and when _____

What were the results? _____

Has your child ever had speech therapy? Yes No

If yes, where and when? _____

What were they working on? _____

Is your child aware of, or frustrated by, any speech/language difficulties? Yes No

If yes, please describe: _____

Language/Communication

Does your child...

- repeat sounds, words, or phrases over and over?
- understand what you are saying?
- retrieve/point to common objects upon request (ball, cup, shoes)?
- follow simple directions (“shut the door” or “get your shoes”)?
- respond correctly to yes/no questions?
- respond correctly to who/what/where/when/why questions?
- respond to their name when called?
- respond to “no” or “stop”?
- know family members’ names?
- repeat words and phrases modeled for them?
- say words without a model (someone saying it first)?

Your child communicates using...

- body language, gestures
- words (shoe, doggy, up)
- sentences longer than four word
- sign language
- sounds (vowels, grunting)
- 2 to 4 word sentences
- AAC
- other: _____

Fluency

Is stuttering a concern? Yes No

If yes, when did the stuttering begin (a date or perhaps a stressful event)?

Frequency:

Is there a family history of stuttering? Yes No

Did stuttering begin after a traumatic event? (birth of siblings, death in family, car accident, etc.)

Yes No If yes, please explain. _____

Social

Do you have concerns with social skills and how your child interacts with others? Yes No

If yes, Please explain. _____

Please check the areas that are difficult for your child:

- Responding to or initiating greetings and farewells from others.
- Initiating conversations with peers
- Asking questions and responding to questions during conversations
- Making on topic comments and maintaining conversational topic
- Expressing their feelings in an appropriate way.
- Respecting personal space
- Responding to his/her name
- Playing well with other children
- Taking turns during play

Articulation:

Do you have difficulty understanding what your child is saying? Yes No

If yes, Please explain. _____

I can understand my child 0% 25% 50% 75% 100% of the time.

Other people can understand my child 0% 25% 50% 75% 100% of the time.

Are certain sounds mispronounced or omitted from your child's speech? Yes No

If yes, explain which sounds. _____

Voice:

Is your child's voice unpleasant or different from other children's voices? Yes No

If yes, please explain and answer the following questions. If not, you may skip this section.

How long has your child had voice symptoms? _____

Did your child's symptoms begin following a specific event? Yes No

Has your child's voice ever been examined by an ENT? Yes No

Have you brought this concern up with your child's pediatrician? Yes No

Oral/Myofacial

Please check the areas that apply to your child:

- Teeth Grinding
- Snoring
- Use Pacifier
- Thumb/Finger Sucking
- Lip Tie (clipped or unclipped)
- Tongue Tie (clipped or unclipped)

When was the last time your child went to the dentist? _____

Additional Comments:

What else would you like us to know about your child prior to their evaluation?

Parent/Guardian Signature: _____ Date: _____

Patient Attendance Policy

In order for us to ensure the best possible results from therapy, you must actively participate in the program developed for you by attending all scheduled sessions. Please be respectful to your therapist and to other patients who are waiting to be scheduled.

Please contact our office at 405-455-6868 if your child is unable to attend his regularly scheduled therapy appointment. Cancelled appointment notifications must be made 24 hours in advance, except for emergencies and unforeseen illnesses. All requests for changes in your child's therapy schedule will need to be discussed with your child's therapist and front office staff. The following definitions and procedures apply to all attendance topics.

Please notify us of upcoming pre-planned trips as soon as possible. Families who are planning to be absent for greater than 2 weeks will be removed from their treatment schedule, unless previously arranged with your therapist and the office.

No Show Appointment Definition: A no show is any missed appointment without a phone call to cancel the appointment(s) **a minimum of 24 hours in advance**. This does not apply to appointments that are rescheduled by your provider.

Cancellation Definition: Any appointment canceled by phone or in person **at least 24 hours in advance**. An appointment that is rescheduled does NOT count as a cancellation.

Late Arrival Definition: A late arrival occurs any time the child is more than 10 minutes late for their scheduled appointment. If the appointment is scheduled for 3 p.m., and you arrive at 3:11 p.m., you are considered late. If your arrival or availability time is 15 minutes or more after your scheduled appointment time, your appointment may be canceled.

If you are unsure about whether you can arrive within 10 minutes of your appointment time, call the clinic to inform them you are running late. Your therapist will determine whether you should reschedule the appointment.

Late Pick-up Definition:

It is also necessary that you pick your child up on time, as to not interfere with another child's therapy appointment. A late pick-up occurs any time the parent is 5 minutes late for their scheduled pick up time. If you are scheduled to pick up at 3 p.m., and you arrive at 3:05 p.m., you are considered late.

A consistent pattern of late arrivals and/or pick-ups will result in a review of your services and possible cancellation of services from Cornerstone Behavioral Health & Pediatric Therapies. We feel the allotted time for your child's treatment is necessary for adequate rehabilitation of their condition.

***Please Note:** Therapists are only paid when the child is present. Due to limited scheduling availability, we ask that all patients attend their scheduled treatments. When an appointment is applied to our schedule, that time is reserved to meet your child's needs. We work hard to accommodate each of our patients. Continuous neglect to follow the regulations stated in this policy could lead to termination and/or change of status to your remaining treatments and/or sessions. Thank you in advance for your understanding and cooperation in this matter.*

In the following instances, your child will be taken off the therapy schedule and placed on a waiting list:

- 1. After 2 No-Show Appointments.**
- 2. After 3 Cancellations in a 9-week period. Cancellations that are rescheduled and attended will not count against you.**

Late and No Show Fees:

Late Arrivals Fee: A late arrival occurs any time the child is more than 15 minutes late for their scheduled appointment. If the appointment is scheduled for 3 p.m., and you arrive at 3:16 p.m., you are considered late and there will be a \$15 charge every 15 minutes that you are late.

Late Pick-up Fee

A late pick-up occurs any time the parent is 5 minutes late for their scheduled pick up time so as not to interfere with another client's scheduled appointment time. If you are scheduled to pick up at 3 p.m., and you arrive at 3:05 p.m., you are considered late and there will be a \$5 charge every 5 minutes that you are late.:

Failure to Cancel / No Show Fee

It is our policy that **if you fail to cancel, or no show, a scheduled appointment a minimum of 24 hours in advance, you will be charged a \$25.00 fee for the missed appointment.* If your child misses more than one therapy, you will be charged this fee for each hour.** This balance on your account will not be covered by insurance and will need to be paid before scheduling any additional appointments.

**Medicaid clients will not be charged the fee*

ILLNESS

For the safety of other children and our staff, please do not bring your child to therapy if your child is ill. When your child is sick, please call the clinic to cancel your appointment as soon as possible. Below are guidelines to assist you in deciding whether your child should attend the appointment.

If a child arrives and/or is brought to Cornerstone Behavioral Health & Pediatric Therapies and is believed to be ill or contagious, the guardian will be contacted immediately and will be responsible for picking up, or making arrangements for picking up, the child as soon as possible.

Children should be kept at home when they meet the following criteria:

- Temperature of 99.9°, or higher, in the past 24 hours.
- Conjunctivitis ("pink eye"), pink/redness of the eye and/or lids, usually with yellow discharge and crusting.
- Bronchitis, COVID-19*, virus/flu with hoarseness, cough, and fever.
- A rash you cannot identify which has not been diagnosed.
- Impetigo: red pimples, which become small vesicles surrounded by a reddened area. When blisters break, the surface is raw and weeping. Look for signs in neck creases, groin, underarms, face, hands, or edge of diaper.
- Diarrhea three or more times within 24 hours (watery or greenish BM's that look different and are more frequent than usual).
- Vomiting within 24 hours (more than usual "spitting up").
- A severe cold with fever, sneezing, and nose drainage.
- An unknown illness without obvious symptoms other than unusual paleness, irritability, tiredness, or lack of interest.
- A contagious disease, including measles, chicken pox, mumps, roseola, strep throat, etc.
- Hair lice (same as public school policy).

While we regret the inconvenience caused by strict adherence to these guidelines, our concern for all the children dictates a very conservative approach when dealing with health matters.

Safe Return After an Illness:

Usually a child can return to the clinic under these circumstances except for cases of COVID-19:

- The child has been fever free for 24 hours.
- The child has been diagnosed as having a bacterial infection and has been on an antibiotic for 24 hours.
- It has been 24 hours since the last episode of vomiting or diarrhea.
- The nasal discharge is not thick, yellow, or green.
- Eyes are no longer discharging, or the condition has been treated with an antibiotic for 24 hours.
- The rash has subsided, or a physician has determined that the rash is not contagious.

***Physician documentation is required.**

Individuals who have tested positive for COVID-19 should not return until the following criteria have been met:

- 10 days since symptoms first appeared (the time it takes to shed the virus) **and**
- At least 36 hours of no fever without fever-reducing medication **and**
- Absence of respiratory symptoms **or**
- Two consecutive negative COVID-19 tests 24 hours apart **or**
- A release from a physician stating the individual may return to school or work

Inclement Weather

In the event of inclement weather, Cornerstone will cancel sessions when local schools close (Edmond PS & Mid-Del PS, or local district of home or community services). Office will attempt to notify parents by text or phone call. If you are unable to keep an appointment due to weather conditions, please notify the clinic at Ext.1, as soon as possible. Occasionally, we may reopen the office if it is determined that streets are clear and safe for travel.

**Please be informed that if your insurance requires a prior-authorization for therapy and you only attend a portion of your sessions, your insurance company will likely reduce the number of visits in future authorizations or completely deny future requests.*

Acknowledgment- I have read the attendance policy and acknowledge my understanding as well as agree to the terms.

Patient Name

Signature of Parent or Guardian

Date



Cornerstone Behavioral Health and Pediatric Therapies, Inc.

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 IT CAREFULLY.

If you have any questions about this notice please contact Carolyn Donaghey at Cornerstone Behavioral Health and Pediatric Therapies, Inc. at (405) 455-6868 or by email at office@cornerstoneok.org

This Notice of Privacy Practices describes how Cornerstone Behavioral Health and Pediatric Therapies may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Cornerstone Behavioral Health and Pediatric Therapies is required to abide by the terms of this Notice of Privacy Practices. Cornerstone Behavioral Health and Pediatric Therapies may change the terms of this notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION: Treatment: Information about you may be used by the personnel (including students in the field of speech- language pathology who are completing extern placements) associated with Cornerstone Behavioral Health and Pediatric Therapies for diagnosis, treatment planning, and treatment. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian or personal representative. It is the policy of Cornerstone Behavioral Health and Pediatric Therapies to release private health information only to clients or the parents/guardians of clients if clients are minors. In some cases, should Cornerstone Behavioral Health and Pediatric Therapies need to send information to another professional, a signed Release of Information form is required.

Payment: Cornerstone Behavioral Health and Pediatric Therapies bills directly to insurance companies. You will be given a Notification of Benefits and Financial Responsibility form. You will be responsible for all services rendered that are not covered by your insurance in addition to any co-payments and/or co-insurance amounts required.

Cornerstone Behavioral Health and Pediatric Therapies will communicate with you only in ways you have provided on the Contact Information form you completed prior to starting therapy. It is the client's responsibility to update contact information with Cornerstone Behavioral Health and Pediatric Therapies.

OTHER DISCLOSURES: Cornerstone Behavioral Health and Pediatric Therapies may use or disclose your protected health information in some situations without your authorization or providing you the opportunity to agree or object. Some of these situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your protected health information to researchers when their research has been



approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. Copies can be obtained for \$.25 a page.

Under federal law, however, you may not inspect or copy records related to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. Depending on the circumstances, a decision to deny access may be reviewable.

You have the right to revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to request that information about you be communicated by other means or to another location.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

COMPLAINTS: If you believe your rights have been violated by Cornerstone Behavioral Health and Pediatric Therapies please bring the problem to our attention first. Your concerns will be addressed in a timely manner. If you are not satisfied with the manner in which the Clinical Director, Dr. Gotcher, PhD (ngotcher@cornerstoneok.org or 405-455-6868) handles a complaint, you may submit a formal complaint to:

Attn: Director Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201

This notice was published and becomes effective on signed date below. It will remain in effect for two years from this date.

Legal Guardian Signature

Date

Cornerstone Representative Signature

Date

Authorization for Release of Information

Patient Name: _____ Date of Birth: ____/____/____

I authorize Cornerstone to release information TO:

1. Name of Provider/ Facility: _____

Address: _____

Phone number: _____

Fax number: _____

Information requested/authorized: Evaluation Records Other: _____

2. Name of Provider/ Facility: _____

Address: _____

Phone number: _____

Fax number: _____

Information requested/authorized: Evaluation Records Other: _____

I authorize Cornerstone to obtain information FROM:

1. Name of Provider/Facility: _____

Address: _____

Phone number: _____

Fax number: _____

Information requested/authorized: Evaluation Records Other: _____

Signature of Parent or Guardian

Date

Cornerstone Representative

Date



Financial Responsibility Statement

Patient full name: _____

Patient's DOB: ____/____/____

Primary Insurance: _____

Policy Holder Name: _____ Date of birth: _____

Member ID Number: _____ Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____ Date of birth: _____

Member ID Number: _____ Group Number: _____

Phone Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Cornerstone Behavioral Pediatrics, and authorize Cornerstone Behavioral Pediatrics to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

By signing this form I am stating that I understand and agree to the following:

Fees for services were reviewed with me and agreed upon prior to the commencement of services. Payment is due at the time services are rendered unless other arrangements have been made. All returned checks will result in a \$25.00 return fee. Failure to meet financial obligations will result in termination of services.

I, _____, (print name) assume all financial responsibility for charges related to all services provided by Cornerstone BH&PT for _____ (print child's name).

Signature of Parent or Legal Guardian

Date