Cornerstone
BEHAVIORAL HEALTH
PEDIATRIC THERAPIES

Counseling Intake Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Patient Name:_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Name of parent/guardian(s) : _____

Parent's Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address:_____

City: _____State: _____Zip: _____

Phone Number: _____

E-mail: _____

Referred by: _____

Please list all persons currently residing with the patient:

Name	Age	Relationship to patient

___

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes

If so, please provide the names of your child's previous mental health providers:_____

_____

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Is there a history of mental health disorders in your family?

☐ Yes ☐ No

If so, please list below:

Name	Age	Mental Health Disorder

___

Has your child ever been prescribed prescription medication?

☐ Yes ☐ No

If so, please list below:

Medication name	Dates

___

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

How would you rate your child's current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems your child is currently experiencing: _____

_____

_____

Is your child currently experiencing overwhelming sadness, grief or depression?

☐ No

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☐ Yes.

If so, for approximately how long? _____

Is your child currently experiencing anxiety, panic attacks or have any phobias?

☐ No

☐ Yes. If so, for approximately how long? _____

Is your child experiencing anger or defiant behavior?

If so, please describe: _____

_____

_____

If so, when did the behavior begin? _____

_____

What significant life changes or stressful events has your child experienced recently:_____

_____

_____

PARENTAL INFORMATION:

Are you currently employed? ☐ Yes ☐ No

If so, please list the name and address of your employer:_____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

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Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If so, describe your faith or belief: _____

What do you consider to be some of your child's strengths?

_____

_____

_____

What do you consider to be some of your child's weaknesses?

_____

_____

What would you like to accomplish out of your child's time in therapy?

_____

_____

QUESTIONS FOR TEEN CLIENTS

Does your teenager drink alcohol more than once a month? ☐ Yes ☐ No

Does your teenager engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Is your teen currently in a romantic relationship? ☐ Yes ☐ No

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship with your child? _____

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Sessions

Sessions are normally from 60 minutes in length though this may vary based on your child's individual treatment plan with your therapist.

Please arrive promptly for sessions. Sessions will end at the designated time regardless of when it was started.

Cancellations

We understand that you may need to cancel an appointment. It is helpful for us to know if you will not be coming, so we ask that you give us **24 hours** notice for any change or cancellation. Any late cancellation (less than 24 hours notice), change or missed appointment will be charged the full agreed upon session rate.

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. 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. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. Minors/Guardianship Parents or legal guardians of non- emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payors are given information requested regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

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I agree to the above limits of confidentiality and understand

Client or Parent signature_____

Text messaging is a popular form of communication. If you choose to text your therapist, this information is at risk as this is not a confidential mode of communication. Please clarify how you would like to communicate with your therapist and if you do choose to text, please keep it to a minimum and use it only for scheduling/logistic purposes.

Client or Parent signature_____

PAYMENT AGREEMENT (Initial each line item and sign below)

_____ I understand that it is my responsibility to contact my insurance company and verify my benefits.

_____ I am financially responsible for payments that my insurance does not pay for.

_____ Phone calls in excess of 10 minutes will be billed to the client's account in accordance with the standard session fee.

_____Treatment may be interrupted or terminated; after 3 unpaid no shows, due to 3 consecutive cancellations, or after unresolved debt of 3 or more sessions.

_____I understand that my therapist will not get involved in any legal proceedings of any kind including but not limited to custody disputes and divorce proceedings.

By initialing each line item above and by signing below, I acknowledge that I understand and commit to the above Payment Agreement and enter into the agreement willingly and voluntarily.

Client Name (please print): _____

Signature of Client or Legal Guardian:
_____Date:_____

Signature of Therapist: _____Date:_____

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Consent for Child and/or Family Therapy involving a Minor

Prior to beginning treatment, it is important for you to understand your providers approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. Under HIPAA and the Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient, privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status, I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

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_____ _____

Patient Name Patient DOB

_____ _____

Signature of Parent or Guardian Date of Consent

Cornerstone Client Rights

Each client shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

Each client has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.

No client shall be neglected or sexually, physically, verbally or otherwise abused.

Each client shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A client shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those clients adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each client shall have the right to the following:

Allow other individuals of the client's choice participate in the client's treatment and with the client's consent;

To be free from unnecessary, inappropriate, or excessive treatment.

To participate in client's own treatment planning.

To receive treatment for co-occurring disorders if present.

To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and

To not be discharged for displaying symptoms of the client's disorder.

Every client's record shall be treated in a confidential manner.

No client shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.

A client shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

Each client has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.

No client shall be retaliated against or subjected to any adverse change of conditions or treatment because the client asserted his or her rights.

Please Initial and Sign Below

My client rights have been reviewed.

I have received a copy of my client rights.

I have been informed of how to file a grievance with Cornerstone

_____ _____

Patient Name Patient DOB

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_____

_____

Signature of Parent or Guardian Date of Consent

Consent for Mental Health Evaluation and/or Treatment

I consent to the evaluation and/or treatment of _____ at Cornerstone Behavioral Health and Pediatric Therapies and authorize the qualified personnel thereof to perform such diagnostic procedures and administer such care and treatments as may be directed by the clinic policy or ordered and/or prescribed by the clinical staff person who is responsible for my child's care. The information herein is in addition to the information contained in the Cornerstone Notice of Privacy Practices.

I acknowledge that I have been fully informed of the evaluation procedures; care and/or treatment of my child, and any risks associated with it have been addressed to my satisfaction. I understand that I may be asked to participate in my child's therapy/ evaluation. I understand that the professionals and staff of Cornerstone Behavioral Health and Pediatric Therapies are required by Oklahoma law to report reasonable suspicions of child maltreatment. I understand that if I or my child is in danger of hurting ourselves or others, this information may be reported in order to obtain appropriate protection. I understand that professionals and staff of Cornerstone will keep records and information regarding my child's treatment confidential, except as authorized by me, as required by law, or as needed to protect persons from harm and to respond to reasonable suspicions that harm has occurred. I understand that Cornerstone professionals and staff may share information among themselves for the purposes of coordinating care, professional consultation and for other purposes necessary to carry out regular clinic operations. I understand that the information shared will be the minimum necessary to carry out these activities. I give permission for the person who brings my child for an evaluation and/or treatment to provide and to receive information concerning him/her.

I understand and agree that Cornerstone does not perform custody evaluations for children or forensic evaluations (to examine and evaluate a patient in anticipation of prosecution or litigation. I agree not to use Cornerstone's evaluation or treatment information to gain advantage in any legal proceedings related to a custodial arrangement. Additionally, I agree that in any such proceedings, I will not ask Cornerstone staff to testify in court, whether in person, or by affidavit. I agree to instruct attorneys not to subpoena Cornerstone staff or to refer in any court filing to anything Cornerstone staff have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If Cornerstone professionals are required to testify, Cornerstone professionals are ethically bound not to give their opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, Cornerstone professionals will provide information as needed (if appropriate releases are signed or a court order is provided), but Cornerstone professionals will not make any recommendation about the final decision.

Furthermore, if Cornerstone professionals are required to appear as a witness, the party responsible for Cornerstone professional's participation agrees to reimburse Cornerstone Behavioral Health & Pediatric Therapies at the rate of $750 per hour for time spent traveling, preparing reports, testifying, being in attendance and any

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other case-related costs.

I understand and agree that the professionals and staff of Cornerstone, when services are billed to a 3rd party insurance provider, will contact and provide information to my insurance carrier in order to obtain payment for evaluation and/or treatment services, and to document the child's evaluation results, treatment plan (if any), and diagnosis (as required by applicable contracts). I understand that payment or co-payment, if applicable, is due at the time of service, unless other arrangements have been made in advance.

The information in this consent has been discussed with me. I have been given the opportunity to ask questions I have regarding this consent. I am legally authorized to consent to the services provided by Cornerstone for the above-named child patient.

_____	_____
Patient Name	Patient DOB
_____	_____
Signature of Parent or Guardian	Date of Consent

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Patient Attendance Policy

Cancelation Fee not Applicable to those with SoonerCare Insurance. 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 by adhering to the following:

Sick Policy: If your child has had a fever (99 degrees or above), nausea, vomiting, or diarrhea in the past 24 hours, do not bring them to therapy. Call and let the office know. In order to resume therapy, your child must be fever and symptom free for **24 hours**.

Appointment Cancellation Policy: Call at least 24 hours in advance to cancel or reschedule any appointments. Cancellations under 24 hours are acceptable only due to illness, death in the family, or other significant family emergencies. Frequent cancellations (25% or more of total visits) will result in a **$25.00 fee** for future missed visits. We try to offer appointment times that are most convenient for your busy schedule. If you need to reschedule your appointment with short notice, please understand that you may need to see another therapist, accept a less than optimal appointment time, or wait until the next scheduled opening becomes available.

Appointment No Show Policy: Our therapists have set aside a specific time to provide your therapy. When you do not call to cancel or do not show for your appointment, this is time the therapist could be providing therapy to someone else. We understand emergencies do arise requiring schedule changes, however, we do expect a call. After three missed appointments with no notification, you will lose your scheduled appointment time. You will receive one phone call notifying you and then it will be up to you to reschedule. Once rescheduled, any future missed appointments without a 24-hour advanced notification will result in being charged the **full therapy amount.** This balance on your account will not be covered by insurance and will need to be paid before scheduling any additional appointments.

All cancellations or no shows will be reported to your referring physician and insurance company. We are not responsible for any resultant adverse effects.

**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 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

_____ _____

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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 OR YOUR CHILD MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FOLLOWING CAREFULLY.

If you have any questions about this notice please contact Carolyn Donaghey at Cornerstone Behavioral Health and Pediatric Therapies 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 as well as other purposes 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, mental health 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 maintained at that time. You may request a revised version of Privacy Practices by accessing our website or calling the office and requesting 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, the client's legal guardian or personal representative. It is the policy of Cornerstone Behavioral Health and Pediatric Therapies to release private health information to clients or the parents/guardians of clients who are minors. 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 your insurance company. You will be given a Notification of Benefits and Financial Responsibility form. You will be responsible for all services rendered which are not covered by your insurance as well as pay any co-payments and/or co-insurance amounts required.

Cornerstone Behavioral Health and Pediatric Therapies will communicate with you only in forms of communication 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 certain 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 which 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.

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Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority which 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 including audits, investigations and inspections. Oversight agencies seeking this information include government agencies which 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, reporting adverse events, product defects or problems, biologic product deviations, tracking products, enabling product recalls, making repairs/replacements or conducting 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.

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YOUR RIGHTS:

You have the right to inspect and copy your protected health information. Meaning 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 from our office.

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 and you may request 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 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

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Financial Responsibility Statement

Patient Information:

Patient's full name: _____

Patient's DOB: ____/____/_____

Patient's sex: M_____ F_____

Patient's relationship to subscriber: Self___ Child_____ Other_____

Subscriber Information:

Name of subscriber: _____

Subscriber DOB: ____/____/_____

Insurance Company: _____

Member ID:_____

Group 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 Health & Pediatric Therapy, and authorize Cornerstone Behavioral Health & Pediatric Therapy 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 Guardian Date

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Authorization for Release of Information

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

I authorize Cornerstone to release information TO:

1. Name of Provider or Facility:_____

   Address:_____

   Phone number:_____

   Fax number:_____

   Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

2. Name of Provider or Facility:_____

   Address:_____

   Phone number:_____

   Fax number:_____

   Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

I authorize Cornerstone to obtain information FROM:

1. Name of Provider or Facility:_____

   Address:_____

   Phone number:_____

   Fax number:_____

   Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

_____ _____

Signature of Parent or Guardian Date

_____ _____

Cornerstone Representative Date