Cornerstone Counseling and Education

859 S Yellowstone Hwy Suite #304, Rexburg, Idaho 83440
Phone: 208-313-7464 Fax:208-907-0972

Patient Name: _____Date_____

Preferred name/nickname_____Gender_____

Address_____
City_____State_____Zip_____
Phone: _____ Email Address_____
SS#_____ Date of Birth_____ Age_____

Occupation: _____Employer: _____
Who may we thank for referring you? _____

Emergency Contact: _____Phone: _____

Responsible Party for Authorization of Mental Health Services and Payment
(Write same as above or self if it is the same person)

Name: _____ SS# _____
Address: _____Phone: _____
City: _____ State: _____ Zip: _____
Birthdate: _____

Primary Insurance

Name of Insurance Company: _____
Name of Policy Holder: _____DOB _____
Policy Number: _____ Group #: _____

Secondary Insurance

Name of Insurance Company: _____
Name of Policy Holder: _____DOB _____
Policy Number: _____ Group #: _____

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MARITAL/RELATIONSHIP STATUS (CIRCLE)

Married Divorced Single Living Together Separated Widowed

Name of Souse/significant other: _____

Year married: Present Marriage _____ Previous Marriage _____

Names of Children	Gender	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY (Circle)

Appetite: Good Average Poor Sleep: Good Average Poor

Alcohol: Yes No Tobacco: Yes No Drugs: Yes No

Thyroid: Yes No High Blood Pressure: Yes No Diabetes: Yes No

Current medical issues: _____

_____

Serious accidents, illnesses or hospitalizations: _____

_____

Please list all medications and dosages:

Medication	Dosage	Doctor	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER:

Do you presently feel suicidal? _____

Briefly describe what difficulties or issues have brought you to seek help at this time:

_____

_____

_____

_____

When did these issues begin? _____

Have you been to counseling before? Yes or No

If so, when and with whom _____

Have you ever been diagnosed with a mental health disorder? Please explain

_____

_____

Church/ Religious affiliation/ Spirituality _____

Additional information you feel may be helpful for treatment:

_____

_____

_____

Please list desired outcome/goals of participation in treatment at this time:

1) _____
2) _____
3) _____
4) _____

Please Note: If you feel suicidal after office hours or you are unable to reach your therapist at any time please call the suicide hotline at 1-800-227-8922 or your psychiatrist/physician emergency phone or go to the nearest hospital emergency room. Cornerstone Counseling staff does not operate as a crisis center and we do not carry pagers. We are available during the office hours.

_____ _____

Signature Date

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Financial Policy and Contract for Services

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of our care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

- **Payment is expected at each session or at a minimum of once per month** unless alternate financial arrangements are made in advance.
- **All forms of insurance must be reported to the billing office.** If you fail to provide copies of your insurance information or notify Cornerstone of any changes you may be charged a reprocessing fee.
- We assist all our patients by preparing and forwarding insurance claims to insurance companies. We are willing to work with you regarding payment for services provided. If payments are not received as agreed the account can and will be assigned to an outside collection agency.
- **I understand that regardless of insurance coverage, I am responsible for all charges and payments.**
- **Minor Patients:** For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

I authorize **Cornerstone Counseling** to receive assignment of insurance payments. **Cornerstone Counseling** is hereby authorized to release medical information to my health insurance company that may be necessary to processing claims.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____	_____	_____
Responsible Party Signature	Relationship to Patient	Date

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Patient Information and Consent

Appointments:
Office visits are by appointment only.

Cancellations: We request that cancellations be made **at least 24 hours in advance** of scheduled appointments or **you will be charged a late cancel fee of $100.**

Fees, Billing and Insurance:
Insurance information will be gathered and assessed prior to the appointment. Fees vary according to the type of appointment. Co-payments are expected at the time of service. You are responsible for all fees for services delivered, although other persons or insurance may make payments on your account. There is a $35 charge for all returned checks.

Confidentiality:
The information discussed during your appointment is confidential. That is, it cannot be shared with others unless permission is granted by you. If you wish to have us communicate information to others, we will ask you to sign a "consent to Release Information" form. *Limited confidential information can be released by Cornerstone without your consent in extraordinary situations involving: (1) suspected neglect or abuse of a child, or (2) life threatening danger to you or others, as in cases of very high suicide risk or threats of bodily harm against others, (3) if so ordered by a court or required by applicable law.

Emergency and After-Hours Coverage:
If an emergency arises after business hours, you can either call the Crisis Service at the Behavioral Health Center at (208)227-2260 (24 hours/day) or the Rexburg Family Crisis Center (208) 356-0065 (24 Hours/day). Or call 911

Non-Payment of Services:
Cornerstone may exercise the right to terminate services for non-payment of services rendered (see financial policy).

_____	_____	_____
Responsible Party Signature	Relationship to Patient	Date

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Release of Information Authorization Form for Protected Health Information (PHI)

INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name: _____ Date of Birth: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

I understand protected health information is information that identifies me. The purpose of this authorization is to allow **Cornerstone Counseling** to share my protected health information as set forth below, for reasons in addition to those already permitted by law.

PERSON/ORGANIZATION AUTHORIZED TO EXCHANGE MY INFORAMTION

Name, Address, Phone & Fax	Relationship	Purpose

INFORMATION TO BE SHARED (EX. THERAPY NOTES, TREATMETN PLAN, DIAGNOSIS)

_____

This authorization will expire 12 months from date it is signed. I understand I may change this authorization at any time in writing. I understand that I cannot restrict information that may have already been shared based on authorization.

Authorized Representative Signature	Relationship	Date

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Patient Email and Text Information and Disclosure

Please Read Carefully

- Email and text are effective ways to communicate. However, Email messages and text messages although convenient are at risk of being intercepted.
- Email and text cannot be recalled or cancelled once it has been sent
- Errors in transmission can occur
- Neither you nor the person reading your email and text can see the facial expressions or gestures or hear the voice of the sender, making misinterpretation possible.
- At your providers discretion, your email and/or text message and any responses to them may become part of your medical record.
- If you attend group and have group texts going with your fellow group members there is a greater risk as well.

Communications over the internet and/or text message may not be encrypted and therefor may not be secure. Because of this there is no assurance of confidentiality, integrity and availability of communication itself. There is a risk of cyber security being compromised.

Please sign if you agree to the risks of email and/or text communications.

I understand and agree to receive and send email and/or text communications.

_____	_____	_____
Patient	Relationship to Patient	Date

_____
Signature of authorized representative

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Notice of Privacy Practices (NPP)

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of the patient records ("the privacy rules"), and storage and access to health care records ("the security rules"), HIPPA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients with a notice of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you do not have formal legal training. This form is an attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we do everything possible to protect the privacy of your mental health records. If you have any questions about any of the matters in this document, please do not hesitate to ask for futher clarification.

By law, we are required to secure your signature indicating that you have been given the Patient Notification of Privacy Rights Document.

I acknowledge that I understand my rights under the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____

Signature of Patient or Guardian Date

_____ _____

Printed name of Signer and relationship

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Credit Card Authorization Form

Fees: Initial Visit for self-pay is $120, each 50-minute session is $100 per session. Time spent on phone calls will incur prorated hourly charges after the first 10 minutes. Time spent reading lengthy emails may also be subject to an hourly charge.

Letters such as pet letters, disability letters or any other letters that you need written from your therapist are subject to $35-$50 charge at your therapists' discretion.

Please note: Except under extraordinary circumstances, clients will be billed the full fee for all appointments not canceled with at least 24-hour notice. You may leave a message on voice mail on weekends or after hours to cancel an appointment. Insurance will NOT pay for missed appointments. If you are receiving financial assistance from a church or other organization, please be aware that you will be charges for the full session rate for appointments not cancelled with 24-hour notice.

Payment is expected at the time of each session

Each session that you are seen will be charged either your copay amount or if you are self-pay $100 for the session. A $35 fee will be charged for each returned check. Please discuss any unusual circumstances with your therapist.

It is part of our policy to have a debit/credit card on file in order to run for payment of copays, self-pay fees and no-show fees.

Card Number _____

Exp Date _____ Security Code _____ Zip Code _____

I understand that my card as indicated above will be run as frequently as agreed.
Automatic payments will continue until I have given written notice to stop.
I agree to the terms and conditions of the card authorization.

_____ _____
Signature Date

For Office Use: Copay Amount _____ Self Pay Amount_____
Lifestar Group Amount _____

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Mental Health Questionnaire

Listed below are some common problems/symptoms people may bring to therapy. Please check all that apply. Rate the following on a scale of 1-10, with 1 being the least severe and 10 being the most severe.

*Mark (X) yes or no *Rate 1-10

Yes	No	Rate	Symptom
			Anger
			Abuse Victim
			Aggression/Violence
			Anxiety
			Attention/ Concentration
			Compulsions
			Confusion
			Depression
			Divorce/Separation
			Education
			Marital Problems
			Fears Specific to Objects or Events
			Grieving/Mourning
			Impulsiveness
			Financial Problems
			Work
			Compulsive Eating
			Self Esteem
			Mood Swings
			Problems with Children
			Problems with Parents
			Problems with Social Relationships
			Religious and/or Spiritual Concerns
			Self-Harming Behavior
			Sexual Concerns

Yes	No	Rate	Symptom
			Thoughts of Suicide
			Trouble Making Decisions
			Unhappy Most of the Time
			Unwanted/Intrusive Thoughts
			Sexual Addiction
			Eating Disorders/Body Image Issues
			Medical/Physical Problems
			Legal Problems
			Co-dependency
			Substance Abuse
			Perfectionism/Control Issues

LEVEL 2—Anxiety—Adult*

*PROMIS Emotional Distress—Anxiety—Short Form

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If the measure is being completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____hours/week

Instructions to patient: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (individual receiving care) have been bothered by "feeling nervous, anxious, frightened, worried, or on edge", "feeling panic or being frightened", and/or "avoiding situations that make you anxious" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							Item Score
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt fearful.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt anxious.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt worried.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I found it hard to focus on anything other than my anxiety.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt nervous.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt uneasy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt tense.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Depression—Adult*

*PROMIS Emotional Distress—Depression—Short Form

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "no interest or pleasure in doing things" and/or "feeling down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							Item Score
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt worthless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt that I had nothing to look forward to.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt helpless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt like a failure.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt depressed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt unhappy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	I felt hopeless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	