Cornerstone Counseling

Authorization to Treat, Fees, Professional Disclosure Information (HIPAA) & Client Rights

Our Practice

Cornerstone Counseling, LLC is a cooperative business where mental health professionals practice. The name Cornerstone Counseling is for the purpose of shared office expenses. Each therapist is an independent practitioner. Your contract for services is with your therapist/counselor only and does not include a contract with any other therapists at this site. We do collaborate on clients, at times, respecting your confidentiality. This is to provide you with the best counseling services possible.

The **mission** of Cornerstone Counseling is *to enhance the quality of life for individuals, couples and families by providing professional counseling services to encourage and facilitate personal growth, restore wholeness, and provide hope in a grace-filled, confidential, caring environment that promotes respect and acceptance of each person's life journey.*

Emergency Policy: Cornerstone Counseling does not provide 24-hour crisis response. In case of life-threatening emergency, call 911 or go to your nearest emergency room.

Authorization to Treat

I give my consent to my therapist to provide assessment and therapeutic services to me, within the scope of his/her license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem(s) as quickly as possible. I hereby consent to collaboration between counselors at Cornerstone Counseling as my therapist deems appropriate. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I understand that my therapist will not respond to personal or clinical concerns via text or email, but I will need to schedule an appointment to address those issues. I may contact my therapist in case of emergency by phone to discuss issues or schedule an urgent appointment, but I understand that there are fees for urgent phone calls.

Printed Name of Client______________________________ Date of Birth_____________________

I warrant that I am the individual listed above and would like to receive counseling. I acknowledge that I am aware of the mandating reporting laws in the State of Missouri. I am also aware that I can withdraw the permission to receive psychotherapy at any time. I will take sole responsibility in arranging for the payment for all counseling services for myself.

____ ______________________________

Client Signature/Responsible Party Date

Client Rights

YOU HAVE THE RIGHT:

1. To be treated with consideration and respect.
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement of purposes, goals, techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to affect the on-going counseling relationship.
4. To obtain information about the case record and to have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the on-going treatment plan.
6. To expect complete confidentiality and that no information will be released without written consent.
7. To see and discuss charges and payment record.
8. To refuse any recommended services and be advised of the consequences of this action.

Information Regarding Psychotherapy

1. Psychotherapy may involve remembering unpleasant events and can arouse intense emotions: fear, anger, anxiety, depression, frustration, loneliness and/or helplessness. Also, feelings of relief, energy, power, self-acceptance, and well-being may also occur.
2. Psychotherapy is not always effective and may, in some cases; result in deterioration rather than improvement of a client's psychological functioning.
3. There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. We will attempt to provide treatment that is realistic in both areas.
4. Current research has failed to demonstrate that any one form of psychotherapy is necessarily more effective than any other.
5. Depending upon a client's condition, there may be available alternatives and/or additions to psychotherapy, such as medication or behavior modification. We will make these recommendations if they are appropriate, based upon our assessment.

Confidentiality of Information

Laws insuring your right to privacy protect matters discussed with your therapist. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Cases where information may be disclosed without your consent include:

1. When child abuse is known or suspected (reporting is required by law).
2. When the abuse of an elderly or dependent person is known or suspected (required by law).
3. If you commit a crime against a staff member or another person on the premises.
4. If there is a situation that is potentially life threatening.
5. When your medical records or your counselor are subpoenaed by the court.

Coordination of Treatment

It is important that all health care providers work together. As such, we would like permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. If you prefer to decline consent no information will be shared.

___You may inform my physician(s) ___ I decline to inform my physician

Physician Name: ____

Address:____

Phone:____

Signature and Date:____

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Security and Retention of Records

Your treatment of record and related financial records are kept in a locked file cabinet and/or securely encrypted in electronic medical records. Records will not be made available to others without a signed authorization to release information and payment for the records prior to releasing them. Special rules relating to release of treatment records containing information regarding drug and alcohol abuse include: CFR 42, PART 2 prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is prohibited. Treatment records are retained for a period of seven years following the termination of treatment for adults and until age 28 in the case of minors. At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

Fees and Payment Policy

Senior Therapist (10+ years' experience)	**Fees never covered by insurance*
Intake	**$170** 45- 50 minutes
Psychotherapy	**$130** (40 minutes)**; $150** (50 minutes)
Self-Pay	**$110***(intake); **$100***(counseling) 45 -50 minutes
Therapist	
Self-Pay	**$100*** (intake); **$90*** (counseling) 45 -50 minutes
PLPC/CIT	
Self-Pay	**$70*** (intake); **$60*** (counseling) 45 -50 minutes
No Show/Late Cancel (less than 24 hours)	same rate as session*
FMLA/Letters to Physicians, Employers, Schools	**$100**/hour*
Court Testimony (includes all required time)	**$250**/hour* - $1000.00 minimum
Co-parenting Sessions	**$150 session** (50 minutes)
Letters for Attorneys/Court/Legal	**$100/**hour*
Extended phone calls of more than 5 minutes	**$10** every 5 minutes*

We bill primary insurance companies as courtesy to our clients. It is your bill, not your insurance company that is responsible for your account regardless. We do not bill secondary insurance. *All account balances must be satisfied **within 30 days** of the date services were billed; after that time the credit card you have provided for your file will be charged for the balance due*. If your credit card is declined or if you carry a monthly balance with no payment, a rebilling fee of $10/month will be assessed until the balance is paid. *If it is not paid at that time you may be taken to collections. Except for emergency situations,* **should you cancel an appointment with less than 24 hours' notice or do not come to your scheduled appointment; *the full session fee will be assessed and charged immediately to the credit card on file.***

By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and give informed consent for myself/my child's treatment. I understand that I will be furnished a copy of the consent whenever I request it. My signature below indicates that I have received and read Cornerstone Counseling, LLC's HIPAA agreement and I agree to its terms. I understand that not abiding by these policies may lead to interruption of treatment, termination and/or referral to another professional.

______________________________________ ________________________

Client Signature/Responsible Party Date

Cornerstone Counseling Credit Card Payment Authorization Form

By signing this form you give us permission to debit the amount for all services you have received on and/or after the date indicated. **Please initial the following agreeing with our policies:**

Confidentiality of cell phone and email: If you choose to email your therapist from your personal email account, please limit the contents to basic issues such as scheduling and cancellations. *We will not respond to personal or clinical concerns via regular email.* You can email your therapist confidentially through Therapy Appointment.

If you call us, please be aware that unless we are both on landline phones, the conversation may not be confidential. Likewise, text messages are not confidential.

____ I give permission for my therapist to answer text messages from myself, and understand that text messages are not confidential.

____ I give permission for the therapist treating my minor child to answer text messages from said minor child, and understand that text messages are not confidential.

____ I agree to pay in full for any scheduled appointment for which I fail to appear or do not cancel at least 24 hours in advance.

____ I have provided credit card information to be kept on file and used in the event of a cancellation fee or an account balance that has remained unpaid for 30 days after the date of services were billed.

____ I agree to have my counselor charge my credit card automatically for all sessions in the amount of my session fee or co-pay.

All counselors are independent practitioners; your credit card will be charged to their individual business.

Cardholder Name ____

Cardholder Address____

____

Account Number ____

Expiration Date ___________________ CCV _________ (3 or 4 digit code)

Signature___________________________________ Date__________________

I authorize the above named business to charge the credit/debit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above and for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit/debit card company; so long as the transaction corresponds to the terms indicated in this form. I can at any time, discontinue these charges, but must do so in writing.

updated 3/10/2017