Cornerstone Counseling

817 Kilbourne St Suite G
Bellevue, OH 44811
Phone: 419-483-9411

Fax: 419-483-9247

4444 Galloway Rd.
Sandusky, OH 44870
Phone: 419-621-8773

BILLING INFORMATION

Client:

Name_____ M☐ F☐ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Primary Phone_____ May we identify and leave a message by voice and/or text?_____

Email Address_____

IF CLIENT IS A MINOR OR IS STILL IN HIGH SCHOOL, PLEASE PROVIDE PARENT OR LEGAL GUARDIAN'S INFORMATION.

☐ Client is a minor.

☐ Client is not a minor but enrolled **and** attending high school.

School name_____

Expected graduation date_____

Responsible Party: (If different than Client)

Name_____ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Are you legally married? Yes____ No____

Spouse/partner name_____ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Primary phone_____ Type____ May we identify and leave a message by voice and/or text?_____

Secondary phone_____ Type_____ May we identify and leave a message by voice and/or text?_____

Biological parent information-if client is a minor AND is different from above responsible party:

Name_____ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Are you legally married? Yes____ No____

Spouse/partner name_____ DOB____/____/____ SSN_____-_____-_____

Address_____ City_____ State_____ Zip_____

Primary Phone_____ Type_____ Secondary phone_____ Type_____

Employment:

Employer_____

Address_____ City _____ State_____ Zip_____

Phone_____ Position_____ Full time_____ Part time_____

Spouse/partner employer_____

Address_____ City_____ State_____ Zip_____

Phone_____ Position_____ Full time_____ Part time_____

Insurance:

Insurance provider_____ Phone_____

Address_____ City_____ State_____ Zip_____

Subscriber_____ DOB_____/_____/_____ Policy number_____

Secondary insurance_____ Phone_____

Address_____ City_____ State_____ Zip_____

Subscriber_____ DOB_____/_____/_____Policy number_____

Emergency Contact_____

Relationship to patient_____ Phone_____

Nearest relative not living with you_____ **Phone**_____

Physician_____ **Phone**_____

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Cornerstone Counseling of Bellevue, LLC, the counselors, and other Cornerstone staff may use and share my confidential health information with others to treat me, in order to arrange payment of my bill, and for issues that concern Cornerstone operations and responsibilities.

INSURANCE SIGNATURE REQUIREMENT

By signing below, I hereby authorize payment of medical benefits to Cornerstone Counseling of Bellevue, LLC, for services rendered and authorize Cornerstone Counseling of Bellevue, LLC, to release information acquired in the course of my treatment to my insurance company.

I certify the information on this form is true and correct to the best of my knowledge and will notify Cornerstone of any changes in my status regarding the above information.

Printed: _____

Signature:_____ Date_____

Witness:_____ Date_____

Cornerstone
COUNSELING
Building Solid Foundations for Every Season of Life

ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES & CONSENT TO TREAT

NOTICE OF PRIVACY PRACTICES:

I have read and have been offered a copy of the Notice of Privacy Practices and Clients Rights document.

Client Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____

CONSENT TO TREATMENT:

Your signature below indicates that you have read all the information in our informed consent (located at cornerstonecounseling.co) and agree to treatment by our agency and to abide by our policies during our professional relationship.

Client Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I consent that_____may be treated as a client as Cornerstone Counseling. When it is necessary to schedule appointments during school hours Cornerstone will provide a school excuse slip. We ask for your cooperation in order to provide the timeliest treatment for you and your children.

_____Provided Court Documentation for Custody of Minor child/children if applicable (Per CSWMFT Board Directive)

_____Court Documentation not provided Reason:_____

Parent/Guardian Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____

It is your right to refuse to sign this document.

For Office Use Only

The reason that a standard acknowledgement (such as the above) of the receipt of the notice of privacy practices was not obtained because:

___ Client refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented this office from obtaining it
___ Other:_____

CORNERSTONE COUNSELING OF BELLEVUE, LLC

FINANCIAL ARRANGEMENTS & MENTAL HEALTH SERVICES POLICY

We are committed to providing you with the best possible care and keeping associated cost(s) manageable. Therefore, payment in full is due at the time service is provided unless other financial arrangements are made with our office, in advance.

Insurance:
If you have medical insurance, we would like to help you receive your maximum allowable benefits; therefore we ask that you provide your insurance information to the front office staff at your first appointment and when there are any changes in your insurance coverage. Additionally, we require that each patient pay their deductible, copay, and/or coinsurance payment before each visit. Failure to provide your insurance information may result in our inability to submit your claim(s). Accepting and/or pre-certifying your insurance does not place any financial responsibilities on this practice. **You will ultimately be responsible for any and all unpaid balance(s).**

Our services may not be covered by your insurance provider but our rates do not change per session. It is the insurance company that brings about changes to your policy and/or coverage. The most accurate information about payment per session is available only after you receive your first Explanation of Benefits (EOB) from your insurance company, which can take up to 4-6 weeks.

Being referred to our practice by another physician does not necessarily guarantee that your insurance(s) will cover our services. Please remember that you are fully responsible for all charges incurred; your physician's referral and our verification of your insurance benefits are not a guarantee of payment or a transfer of liability. **Please do not assume that you will not owe a balance if you have insurance or coverage from more than one insurance carrier.**

Billing:
The hourly rate for the requested services is $100/hour and $120 for the diagnostic session. You will be billed for any outstanding balance(s) at the conclusion of your visit(s) with us that may not be covered by applicable insurance(s), etc. **Immediate payment in full is expected and appreciated.** We realize that you may have special arrangements with a non-custodial parent or other party for payment of medical bills; however we do not get involved in domestic issues with third parties.

Any account may be placed with a collection agency. If your account is placed with a collection agency and legal action is initiated, you will be responsible for any amount due including but not limited to interest, fees, charges and/or expenses incidental to the principal obligation prior to a judgment being rendered against you. **A finance charge of 1.5% per month will be assessed on all outstanding balances over 30 days past due.**

Patient Relationship:
The initial three sessions are for the purpose of evaluation (e.g. to determine whether or not a treatment relationship will be established) and as such do not guarantee acceptance as a Cornerstone client. While you likely expect to benefit from this treatment, understand that outcomes cannot be guaranteed. Your therapist is under no obligation to treat you. If there is a credit due you, it may be applied to any future appointments or will be refunded to you at the close of your case.

CANCELLATION POLICY

Because the demand for counseling is so great, we take very seriously our responsibility to be good stewards of our time and resources. **We ask that you give us at least a 24 hour notice of your intention to cancel any counseling appointment.** Failure to show without notice OR same day cancellations will result in the client being billed $50 for the first incident and $100 for each additional incident. We maintain a secure 24-hour answering machine for appointment cancellations. Please leave a reason for your cancellation when leaving a voicemail. We reserve the right to cancel any and all future appointments if you have an account balance of more than $100.

By signing below I acknowledge that I have read the Financial Arrangements & Mental Health Services Policy and the Cancellation Policy, in their entirety and I fully understand their content(s). I also understand that I am ultimately responsible for any and all charges resulting from services rendered.

Printed Name _____ Date _____

Signature _____

Cornerstone Counseling of Bellevue, LLC
Child/Adolescent Personal History

Please complete the following information to the best of your ability. We are required to ask the following information as part of your assessment today. Your counselor will review this information with you as part of the assessment process. This information will be very helpful to your counselor in making recommendations for treatment here. If you are uncomfortable or have difficulty answering any of these questions, you may leave them blank and discuss them with the counselor. We appreciate your patience in completing this form. Please ask our staff if you need any assistance completing this form as we would be happy to help you.

Child's Name _____ **Today's Date** _____

Name of child's legal guardian: _____ Relationship: _____

I. **PRESENTING PROBLEM:**

Who referred the child for services? (Check all that apply): ☐ Self ☐ Family ☐ School
☐ Friend ☐ Employer ☐ Court ☐ Family Doctor/Other health care provider
☐ Other (Please explain) _____

Why are you seeking counseling for the child and/or why did any of the above refer him/her? _____
_____

II. **SOCIAL HISTORY:**

LIVING SITUATION

Identify the child's type of living situation: ☐ House, apt. or trailer with family ☐ Friend's Home ☐ Relative's Home ☐ Foster Care home ☐ Residential Facility ☐ Group Home ☐ Jail/Prison ☐ Hospital (Psychiatric) ☐ Homeless, Living with friend ☐ Homeless in shelter/No residence
Other:

List Household Members (Names)	Relationship to Child	Age	Circle which best describes the child's relationship with each household member			
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
Significant Family Members (Not residing with the child)	Relationship to Child	Age	Circle which best describes the child's relationship with each household member			
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent
			Poor	Fair	Good	Excellent

Would you like any family members involved in the child's treatment? ☐ Yes ☐ No
If yes, List who you would like involved: _____

Community Resources:

Does the child currently use any of the following community resources? Check all that apply:

AA/NA/Al Anon		C.H.A.D.D.		Parents Anonymous	
Adult Protective Services		Health Department		Senior Services	
American Red Cross		Home Health Care		Support Consumer Group	
Big Brothers/Big Sisters		Hospice		Metropolitan Housing	
CASA		Meals on Wheels		None	
Catholic Social Services		MR/DD		Other(s): Please list below	
Dept. of Job & Family Services		NAMI			

Leisure and Recreation Activities:

Please check the appropriate boxes as they apply to the child's leisure/recreation activities:

Activity	Enjoyed in the past	Enjoys now	Comments (Types of activities, etc.)
Shopping			
Arts & Crafts			
Social Activities/Events			
Games			
Music			
Physical Activities			
Pets			
Spending time with friends			
Other:			

Does the child appear to have an age appropriate social life? ☐ Yes ☐ No If no, please comment_____

Developmental History

Place of Birth: _____

Birth: Weight: _____ Length: _____

Prenatal History:

- Medical problems during pregnancy? ☐ Yes ☐ No Comments:_____
- Did parent use drugs/alcohol during pregnancy? ☐ Yes ☐ No Comments:_____
- Pregnancy or birth complications? ☐ Yes ☐ No Comments:_____

Infancy & Early Childhood

- Appeared to bond soon after birth? ☐ Yes ☐ No Comments:_____
- Crawled by 9 months? ☐ Yes ☐ No Comments:_____
- Walked by 18 months? ☐ Yes ☐ No Comments:_____
- Speech: Words by 18 months, sentences by age 3-4? ☐ Yes ☐ No Comments:_____
- Completed toilet training by age 3? ☐ Yes ☐ No Comments:_____

Middle & Late Childhood:

- Has learned physical skills for age? ☐ Yes ☐ No Comments:_____
- Able to play and get along with peers? ☐ Yes ☐ No Comments:_____
- Follows rules at home & away from home? ☐ Yes ☐ No Comments:_____
- Activity level, sleep, appetite normal? ☐ Yes ☐ No Comments:_____
- Maturity level appropriate for age? ☐ Yes ☐ No Comments:_____

Adolescent Years:

- Socializes with friends as expected? ☐ Yes ☐ No Comments:_____
- Follows rules as required by the situation? ☐ Yes ☐ No Comments:_____
- Activity level, sleep, appetite normal? ☐ Yes ☐ No Comments:_____
- Maturity level appropriate for age? ☐ Yes ☐ No Comments:_____

Has the child ever been a victim of the following? (Check all that may apply):

Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Verbal Abuse ☐

Neglect ☐ Exploitation (Taken advantage of in an unethical and/or illegal way) ☐

OTHER:

Any significant illnesses, injuries or surgeries in the child/adolescent's history? ☐ Yes ☐ No If yes, explain: _____

How has the child's/adolescent's condition affected the family? _____

What do you as the parent/guardian of the child expect or hope to gain from treatment? _____

Are you willing to be involved in this child's treatment? ☐ Yes ☐ No If no, explain: _____

III. CULTURAL AND ETHNIC SECTION:

- What is the child's ethnic/cultural heritage? (For ex. Irish, African-American, Native Indian, etc) _____
- What are the child's family's beliefs about the following?

Issue	Comments (My family believed, taught .....)
Discipline	
Taking responsibility for one's actions	
Showing emotions	
Death/dying	
Respecting the laws/rules of society	
Using alcohol/other drugs	
Having a mental illness	
Seeking help	

- Are there any traditions that were/are special to the child's family? (i.e., special holidays, cooking certain foods, music, celebrations, traditions, etc.) _____
- Do you think any family beliefs/cultural beliefs will affect the child's treatment at this agency? ☐ Yes ☐ No
  If yes, explain how: _____

IV. EDUCATION & EMPLOYMENT INFORMATION:

Education History: (Check all that apply) ☐ GED ☐ HS Grad

Name of School: _____ Principals' Name: _____

Highest Grade Completed: _____
Is the child on an IEP at school? ☐ Yes ☐ No If yes, why? _____

Does the child have a history of learning difficulties? ☐ Yes ☐ No
If yes, please check all that apply:
☐ Learning Disability – Type: _____ ☐ Mental Retardation ☐ Special School Placement
☐ Inability to read or write (that is NOT age appropriate) ☐ Other: _____

Does the child have a history of behavior problems/disciplinary action at school? ☐ Yes ☐ No
If yes, please check all that apply:
☐ Detentions for (explain): _____
☐ Suspensions for (explain): _____
☐ Expulsions for (explain): _____

Any school problems related to drug/alcohol use (i.e., disciplinary actions, poor grades, acting out, etc.)? ☐ Yes ☐ No
If yes, explain: _____

Does the child have any special communication needs? ☐ Yes ☐ No
If yes, please check all that apply:
☐ TDD/TTY Device
☐ Sign Language interpreter
☐ Assistive Listening Device(s)
☐ Language Interpreter Services Needed – Other spoken language: _____
☐ Other: _____

Employment/Volunteer Work: (Check all that apply)

Does the child do volunteer work? ☐ Yes ☐ No If yes, where? _____
Is the child employed? ☐ Yes ☐ No

If yes, complete the following:
Employed: ☐ Full time (35 or more hours per week) ☐ Part time (<35 hours per week)

Name of Employer: _____

Identify the child's typical attendance habits at work: ☐ Above average ☐ Normal ☐ Tardiness ☐ Absenteeism

Identify the child's typical work performance: ☐ Excellent ☐ Good ☐ Average ☐ Below average

Does the child have any history of employment problems due to drug/alcohol use? (i.e., disciplinary actions, suspensions, problems relating to bosses/coworkers, termination, etc.) ☐ Yes ☐ No If yes, explain: _____

V. LEGAL HISTORY:

- What is the child's current legal status? ☐ None ☐ On Court Diversion Program ☐ On Probation ☐ Detention ☐ Awaiting charges ☐ Conditional release ☐ Court ordered to treatment ☐ Drug/Alcohol related legal problems ☐ Other: _____

- Does the child have any history of juvenile legal charges? ☐ Yes ☐ No
  If yes, list charges: _____
  Date of most recent charges: _____

- Has the child ever been incarcerated? ☐ Yes ☐ No
  If yes, complete the following:

Date(s) of incarceration	Location	Reason(s)

- Does the child have a Probation Officer? ☐ Yes ☐ No
  If yes, list name: _____ Phone: _____

- Is Children's Protective Services involved with the child or the child's family? ☐ Yes ☐ No
  If yes, why? _____

  If yes, Name of Caseworker: _____ Caseworker's Phone: _____

- Does the child have a Guardian ad Litem? ☐ Yes ☐ No
  If yes, list name: _____ Phone: _____

VI. SPIRITUALITY:

1. Does your child/family believe in God or a Higher Power? ☐ Yes ☐ No
2. Does your child/family identify with any particular faith? ☐ Yes ☐ No
3. Does your child/family attend a church/synagogue/mosque or other place of worship? ☐ Yes ☐ No
   If yes, where? _____
4. Has your child/family turned to their faith for strength/support during difficult times? ☐ Yes ☐ No
5. What are the child's/family's spiritual beliefs about suicide? _____
6. Do you see faith/spirituality playing a role in your child's treatment? ☐ Yes ☐ No
   If yes, Please explain: _____

VII. INTERNET, SOCIAL MEDIA, GAMING HISTORY:

- How many hours per day is your child on the internet/social media for "fun"?
  During the week: _____
  During the weekend: _____
- What are your child's favorite video/online games? _____
- What is your child's favorite app? _____
- Do you know the password(s) to your child's devices/apps? ☐ Yes ☐ No
- Is your child allowed to play LIVE or "online" versions of games where they can talk and interact with other players? ☐ Yes ☐ No
- Where are your child's technology devices stored at night? _____

VIII. ALCOHOL/DRUG USE HISTORY:

- Has the child used illegal drugs in the past 12 months? ☐ Yes ☐ No
- Has the child used prescription drugs different from how they were prescribed (e.g., higher dose or more frequently than prescribed) in the past 12 months? ☐ Yes ☐ No If yes, please explain: _____
- Has the child used non-prescription drugs different from the recommended dosage (e.g., higher dose than recommended) in the past 12 months? ☐ Yes ☐ No If yes, please explain: _____

Complete the following regarding your child's history of drug/alcohol use:	**Date of last use**	**Amount typically used**	**How often?**
Alcohol			
Cannabis (Marijuana, Weed, Pot)			
Opioids (Percocet, Opana, Vicodin, Heroin, etc.)			
Sedatives (Xanax, Benzodiazepines, Klonopin)			
Inhalants (Whippets, Nitrous, Poppers, Rush)			
Hallucinogens (Acid, LSD, PCP)			
Cocaine (Any form)			
Stimulants (Diet pills, Speed, etc.)			
Club/Designer Drugs (Ecstasy/Molly, GHB, LSD, Ketamine)			
Other (i.e., Steroids, Fat Burners, etc.)			

- Tobacco use: ☐ Yes ☐ No If yes, form (cigarettes, cigars, chew)? _____ Amount per week? _____
- Caffeine use: ☐ Yes ☐ No If yes, form (coffee, pop, etc.)? _____ Amount per week? _____

Has your child had any of the following problems related to drug/alcohol use? (Check all that apply)
- ☐ Health problems (medical treatment or hospitalization for conditions related to drug/alcohol use)
- ☐ Legal Problems
- ☐ Relationship problems (Arguments/strained relationships with partner, children, friends, family, etc.)
- ☐ Financial problems (Failing to meet ones financial obligations due to money spent on drugs/alcohol)

Has your child ever received treatment for alcohol and/or drug use? ☐ Yes ☐ No
If yes, please complete the following:

Agency Name	Currently in treatment	Past Treatment (List dates)	Please rate your treatment experience (Circle response) 1 Not helpful 2 3 Helpful 4 5 Very helpful
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5

Client signature or Signature of person completing the form on behalf of the client:	Date:
Parent/Guardian Signature:	Date:
Clinician Signature/Credential:	Date:
Supervisor Signature/Credential:	Date:

CORNERSTONE COUNSELING OF BELLEVUE, LLC

Health History Questionnaire

Please notify staff if you need any assistance in completing this form.

Client Name (First, MI, Last):	Date of Birth:

I. Any Allergies/drug sensitivities? Yes___ No___

If yes specify below:

___Food (Specify):
___Medicine (Specify):
___Other (Specify):

II. Medications: Are you currently taking any prescribed medication, over the counter medication, or herbal remedies? ___Yes ___No If yes, please complete the following:

Medication	Reason	Prescribed by:

III. History of Medical Problems: Please check "self" if any of the following health issues apply to you and/or check "family" if any apply to a family member.

Problem	Self	Family	List any treatment YOU have received for each problem identified.
Alcoholism/Drug Issues			
Anxiety			
Breathing Problems			
High Blood Pressure			
Cancer			
Depression			
Diabetes			
Epilepsy/Seizures			
Head Injury/Brain Tumor			
Heart Disease			
Hepatitis/Jaundice			
Kidney Disease			
Stomach/Bowel Problems			
Stroke			
Thyroid			
Have you tested positive for TB?			
Have you had exposure to TB?			
AIDS/HIV			
Sexual Problems			
Sleep Problems			
Suicidal attempts or thoughts			
Other?			

Any medical/surgical hospitalizations in the past year-please list reasons:		
Do any of the medical problems you checked interfere with your daily living?	Yes	No
If yes, what problems and how?		

IV. Functional Screening

Problem/Difficulty	YES	NO	Treatment received to help with the problem
Do you have problems with activities of daily living i.e. bathing, getting dressed or tying shoes?			
Do you have difficulty walking?			
Do you have any problems performing physical tasks at work or home?			
Do you use a walker, cane, wheelchair, or other ambulatory device?			
Do you exercise regularly? If yes, what type? How often?			
Do any of the issues checked yes interfere with your daily living? If yes, which ones and how do they interfere?			

V. Pain Screening

Do you currently experience physical pain?	Yes	No
If yes, please rate your pain on a scale from 0 (no pain) to 10 (severe/worst pain) (Circle the one that best describes your pain) 0 1 2 3 4 5 6 7 8 9 10 No pain Severe/worst pain		
Please indicate the location of your pain.		
Are you receiving medical treatment for the pain?	Yes	No
Are you taking pain medication	Yes	No
Does the pain interfere with your daily living?	Yes	No
If yes, explain how:		

VI. Speech, Language, Vision, and Hearing Screening

Are you experiencing any of the following at this time? Please check "YES" or "NO".	YES	NO	If yes, list treatment and or services you received to help with these problems.
Do you ever have problems hearing others?			
Have you ever been tested for a hearing problem?			
Do people often ask you to repeat what you are saying?			
Is English your native language?			If no, what is?
Do you have difficulty seeing?			
Do any of the issues checked "yes" interfere with your daily living?			Yes / No
If yes what problems and how?			

VII. Nutritional Screening

Are you currently experiencing any of the following?	**YES**	**NO**	**Details**
Unplanned change in weight in the last 12 months?			If yes, identify the change. __Gain __Loss Have you received medical treatment for this? __Yes __No
Has your physician asked you to follow a special diet?			If yes, type:
Any problems with chewing/swallowing?			If yes explain: Have you received medical treatment for this? __Yes __No

Do any of the issues checked interfere with your daily living? If yes, what problems and how?	Yes	No

VIII. Health Care

Last Physical Examination	**Date:**	**By whom?**	**Phone Number:**

Are your childhood immunizations up to date?	Yes	No
Have you had the flu shot this year?	Yes	No
Have you had a pneumonia vaccine in the last five years?	Yes	No

Pregnancy (If applicable) Are you pregnant at this time? If yes, expected delivery date?	Yes	No	N/A
Are you receiving prenatal care? If yes, by whom?	Yes	No	N/A

Mental Health Treatment History:

Have you previously had outpatient mental health treatment? □ Yes □ No

If yes, please complete the following:

Agency Name	Past Treatment Dates	Please rate your treatment experience (circle rating)		
		Not Helpful	Helpful	Very Helpful
		1	2	3
		1	2	3

Have you ever been hospitalized for psychiatric reasons? □ Yes □ No

If yes, please complete the following:

Hospital Name	Admit Date	Discharge Date	Reason for Entering Hospital

Have you in the past or do you currently have a mental health diagnosis?

□ Yes □ No

If yes, please list diagnosis:

Signature of person completing this form: _____

Email Informed Consent Form

Introduction

Cornerstone Counseling provides patients the opportunity to communicate with Cornerstone Counseling and its employees or agents by email. Transmitting confidential patient information by email, however, has a number of risks, both general and specific, that patients should consider before using email.

Risk Factors

- Among general email risks are the following:
    - Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
    - Recipients can forward email messages to other recipients without the original sender's permission or knowledge.
    - Users can easily misaddress an email.
    - Email is easier to falsify than handwritten or signed documents.
    - Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.

- Among specific patient email risks are the following:
    - Email containing information pertaining to a patient's diagnosis and/or treatment may be included in the patient's medical or financial records. Thus, all individuals who have access to the medical record or financial record will have access to the email messages.
    - Employees do not have an expectation of privacy in email that they send or receive at their place of employment. Thus, patients who send or receive email from their place of employment risk having their employer read their email.
    - If employers or others, such as insurance companies, read an employee's email and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information, they may discriminate against the employee/patient. For example, they may fire the employee, not promote the employee, deny insurance coverage, and the like. In addition, the employee could suffer social stigma from the disclosure of such information.
    - Patients have no way of anticipating how soon Cornerstone Counseling and its employees and agents will respond to a particular email message. Although Cornerstone Counseling and its employees and agents will endeavor to read and respond to email promptly, Cornerstone Counseling cannot guarantee that any particular email message will be read and responded to within any particular period of time. Cornerstone Counseling's employees and agents may be traveling, be engaged in other duties, or be on a vacation or

a break and therefore be unable to continually monitor whether they have received email. Thus, patients should not use email in a medical or other emergency.

Conditions for the Use of Email

- It is the policy of Cornerstone Counseling to make all email messages sent or received that concern the protected health information ("PHI"), defined as individually identifiable health information that includes medical, financial, demographic, and lifestyle information, part of that patient's medical, financial, or other records, and Cornerstone Counseling will treat such email messages with the same degree of confidentiality as afforded other portions of the medical record. Cornerstone Counseling will use reasonable means to protect the security and confidentiality of email information. Because of the risks outlined above, Cornerstone Counseling cannot, however, guarantee the security and confidentiality of email communications.
- Thus, patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:

    - All emails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient's records. As a part of medical record or other records, other individuals, such as other physicians, nurses, physical therapists, patient accounts personnel, and the like, and other entities, such as other health care providers and insurers, may have access to email messages contained in medical records.
    - Cornerstone Counseling may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. Cornerstone Counseling will not, however, forward the email outside the facility without the consent of the patient or as required by law.
    - If the patient sends an email to Cornerstone Counseling one of its employees or agents will endeavor to read the email promptly and to respond promptly, if warranted. Cornerstone Counseling, however, can provide no assurance that the recipient of a particular email will read the email message promptly. **Because Cornerstone Counseling cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical or other emergency.**
    - If a patient's email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient has received the email and when the recipient will respond.
    - Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **patients should not use email for communications concerning diagnosis or treatment of the following: AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug abuse.**

- Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information.
- Cornerstone Counseling cannot guarantee that electronic communications will be private. Cornerstone Counseling will take reasonable steps to protect the confidentiality of patient email, but Cornerstone Counseling is not liable for improper disclosure of confidential information not caused by Cornerstone Counseling's gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Cornerstone Counseling of any types of information that the patient does not want to be sent by email other than those set out above.
- Patient is responsible for protecting patient's password or other means of access to email sent or received from Cornerstone Counseling to protect confidentiality. Cornerstone Counseling is not liable for breaches of confidentiality caused by patient.
- **Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing.** You may withdraw consent to the future use of email at any time by email or written communication to Cornerstone Counseling attention: Staci Ringle

EMAIL INFORMED CONSENT SIGNATURE PAGE

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Cornerstone Counseling regarding my medical treatment.

_____ _____

Signature of Patient or Representative if Minor Date of Signature

_____

Printed Name of Patient

_____ _____

Signature of Witness Date of Signature

_____

Printed Name of Witness

Gave Client Copy_____ Client Declined Copy_____