

817 Kilbourne St Suite G  
Bellevue, OH 44811  
Phone: 419-483-9411  
Fax: 419-483-9247

**Cornerstone Counseling**  
550 Smith Rd  
Fremont, OH 43420  
Phone: 419-483-9411

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 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: EFFECTIVE 1/1/2021

The hourly rate for the requested services is \$110/hour and \$130 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 \$55 for the first incident and \$110 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 \$110.

*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 \_\_\_\_\_



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**  
**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/AI 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: \_\_\_\_\_  Developmental Disability  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:
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**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
If yes what problems and how?			No

**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?		Yes	No	N/A
If yes, expected delivery date?				
Are you receiving prenatal care?		Yes	No	N/A
If yes, by whom?				

**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 \_\_\_\_\_