CORNERSTONE THERAPY AND WELLNESS
(610)616-5935

639 Swedesford Road, Malvern, PA 19355
996 Old Eagle School Road, Suite 1105, Wayne, PA 19087

NEW CLIENT INFORMATION FORM (Please Print)

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GENDER: ○ Male ○ Female MARITAL STATUS: ○ Single ○ Married ○ Partner ○ Divorced ○ Separated ○ OTHER _____

PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: ____/____/_____

CONTACT E-MAIL: _____

WHO REFERRED YOU TO Cornerstone Therapy and Wellness, LLC? _____

PATIENT EMPLOYER INFORMATION: ○ Employed ○ Student ○ OTHER _____

COMPANY/SCHOOL: _____ OCCUPATION: _____

RESPONSIBLE PARTY INFORMATION

☐ **SAME AS ABOVE**

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GENDER: ○ Male ○ Female MARITAL STATUS: ○ Single ○ Married ○ Partner ○ Divorced ○ Separated ○ OTHER _____

PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: ____/____/_____ RELATIONSHIP TO THE PATIENT: _____

EMPLOYER INFORMATION: ○ Employed ○ Student ○ OTHER _____ **CONTACT E-MAIL**: _____

COMPANY/SCHOOL: _____ OCCUPATION: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ INSURANCE ID # OF PATIENT: _____

INSURANCE CO PHONE: _____ COPAY: _____

EMERGENCY CONTACT NAME: _____ PHONE NUMBER: _____

INSURANCE AUTHORIZATION

IN ORDER TO FILE YOUR INSURANCE FOR YOU, WE REQUIRE THAT YOU CHECK <u>EACH</u> BOX AND SIGN THE FOLLOWING SIGNATURE-ON-FILE FORM. (Including EAP)

- ○ I authorize release of my information and claim submissions to all my insurance carriers.
- ○ I understand that I am responsible for my or dependents bill and it is my responsibility to confirm my coverage and benefits. For any reason the submitted claims are not paid within 45 days of the date of service, I will become responsible for the entire bill.
- ○ I authorize **Cornerstone Therapy and Wellness** act as my agent in helping me obtain payment from my insurance carriers.
- ○ I hereby authorize payment directly to Cornerstone Therapy and Wellness, if any, otherwise payable to me for their services as described, realizing I am responsible to pay non-covered services.

Signature: _____ Date: ____/____/_____

FINANCIAL ACCEPTANCE FORM

I (Patient Name/Parent/Guardian) _____, have read the statement below and agree by the terms and conditions.

We will make your payment as easy and convenient as possible. You may pay your copay or deductible by cash, check, credit card or debit card. We require a credit card on file to supportthe cancellation policy.

INITIAL:_____ **I understand that there is a 3% surcharge for every credit/debit card transaction.**

- Credit Card/Debit Card #: xxxx xxxx xxxx _____ (Last 4 #'s) Exp. Date:_____
- Card Type: *Visa / MasterCard / Discover* (circle one)

INITIAL: _____ **I understand that a 24 hr notice is needed for any cancellations or I will be billed the following fees:**

Therapy:	**Psychiatry Med Check:**	**Psychiatry Evaluation:**
$50.00	**$75.00**	**$180.00**

This is not a billable charge to your insurance company. <u>All cancellations need to be made by phone.</u> I also understand that there will be a $30.00 charge for all returned checks.

I authorize Cornerstone Therapy and Wellness to charge my co pay, outstanding balances and/or cancellation fee charged on my account to the provided credit card number/debit card or any replacement credit card that I supply during my treatment period. I also understand that any balance on my account ultimately becomes my responsibility as well as the primary insurance policy holders.

Signature: _____ Date:___/____/_____

<u>Credit card information:</u> (*this section will be detached and destroyed once entered into our (PCI DSS) compliant system*)

- Credit/Debi t Card # _____Expiration Date: _____/_____/_____
- Name on Card: _____Security Code: _____
- Card Type: *Visa / MasterCard / Discover* (circle one)

ACKNOWLEDGEMENT OF RECEIPT:

I acknowledge that I have had adequate opportunity to access, read, review, understand the **"Federal HIPPA Privacy Notice," "Cornerstone's Financial Policy," "Cornerstone's Electronic Communication Agreement"** and my **"Patients Rights and Responsibilities Policy"** located online at **www.cornerstonetherapy.com/patient-forms/** (Paper forms also located at front desk at each practice location.)

CONSENT TO TREATMENT:

I authorize, request, consent and agree to receive treatment /services from Cornerstone Therapy and Wellness. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent will be done in writing and will include the reason for withdrawal.

LIMIT OF PRACTICE:

I understand that the office does not handle any of the following: work grievances, lawsuits, custody disputes, disability determinations, or any other legal administrative proceedings, including work excuses and request for change in job conditions.

GUARANTEE OF PAYMENT:

As the policy holder and/or patient fully understand that I am directly responsible for payment to Cornerstone Therapy and Wellness for the entire services rendered to me. I also understand that my insurance is an agreement between me and my insurance company. As a courtesy, Cornerstone Therapy and Wellness, will file your insurance claims for me. For any reason, the submitted claims are not paid to them within 45 days of the date of service, the policy holder and/or patient will become responsible for the entire bill. If such an event does arise, an itemized bill will be given to me to help process my claims. This is a standard practice within the Mental Health Industry.

FEES FOR ADDITIONAL SERVICES:

I understand there is a fee for a copy of my record if the request comes from anyone other than another state licensed physician or mental health practitioner. (M.D., LCSW, PsyD, LPC, etc.) This fee is outlined and regulated by the PA Department of Health and is available on their web site. (www.health.pa.gov)

PRESCRIPTION REFILLS:

I understand that my physician will give me adequate prescriptions until my next scheduled visit and that is my responsibility as the patient to make the next appointment in the correct time frame to be able to refill my prescription. I also fully understand no refills will be given if I have not seen my physician within 90 days of my last appointment. I also understand no refills will be processed if I have missed or cancelled more than one appointment. I understand that the office does not mail in prescriptions. I also understand controlled substances prescriptions will not be replaced if lost or stolen

By my signature below, I acknowledge that I have read, understood and agree to all the above.

Signature: _____ Date: _____/_____/_____

24 Hour Cancellation Policy

Reason for this policy:

To be effective, counseling and psychotherapy need to take place on a regular basis. The best results occur when appointments are consistently scheduled and attended regularly. Additionally, an appointment time reserved for you means that it cannot be used for someone else. It is reservedfor you and/or your family.

If the policy holder and/or patient do not notify your Therapist/Psychiatrist by phone of your intention to cancel or reschedule 24hrs in advance, you will be charged the following fees:

Therapy:	Psychiatry Med Check:	Psychiatry Evaluation:
$50.00	**$75.00**	**$180.00**

Cancelling or re-scheduling within 24hrs allows the therapist an opportunity to schedule someone else for that time slot. This is important because others may be on a waiting list for or preferred your time slot.

If you reschedule to a later time of the day or week of your scheduled appointment and if there is an opening, the cancellation fee will be waived.

1) You will never be charged for a cancellation that is made more than 24 hours in advance of your scheduled appointment time.

2) This cancellation policy is standard in the mental health field.

3) If you simply do not show up for a scheduled appointment, you will be charged for the missed appointment.

4) This fee is **not** billable to your insurance company and is your out-of-pocket responsibility.

5) Arriving late without notification: Your therapist will wait for you for 15 minutes after which they will assume you are not coming and may leave the office. In such a case, you will be charged for a missed appointment.

6) On occasion, there will be understandable reasons for missing appointments, but, exceptions to this policy will be rare. In the event of illness or work emergency, a phone session is an option. There is no charge for missed appointments due to snow conditions or declared states of emergencies.

If you have questions about this cancellation policy, you should discuss this with your therapist at the start of therapy. Please sign below to indicate you have read, understand, and agree to abide by our cancellation policy. Thank you.

Signature: Date:

This is not a request for patient records.

Authorization to Disclose Personal Health Information to Primary Care Physician

PATIENT INFORMATION:

LAST:	FIRST:	MI:	BIRTHDATE:	DATE:

PRMARY CARE PROVIDER INFORMATION:

PHYSICIAN/PRACTICE NAME:

PHONE:	FAX:

ADDRESS CITY/STATE/ZIP

MENTAL HEALTH PROVIDER INFORMATION: (Information below to be completed by therapist or physician)

Dear Primary Care Provider,

I am sending this form to notify you that I am currently seeing your patient in a therapeutic setting and to provide our offices with a release of information to facilitate communication and to coordinate services in regards to client care. If further information is desired, please contact me at your convenience. ***This is NOT a request for you to send us medical records.***

MAILING ADDRESS:

Cornerstone Therapy and Wellness
639 Swedesford Road, Malvern, PA 19355
996 Old Eagle School Road, Suite 1105 Wayne, PA 19087
Phone: (610) 616-5935
Fax: (484) 318-7166
www.cornerstonetherapy.com

THERAPIST NAME (please print)

CLINICAL INFORMATION:

REASON FOR RELEASE:

DIAGNOSIS:	MEDICATIONS:

TREATMENT PLAN(S) OR RECOMMENDATIONS:

CONSENT AND RELEASE:

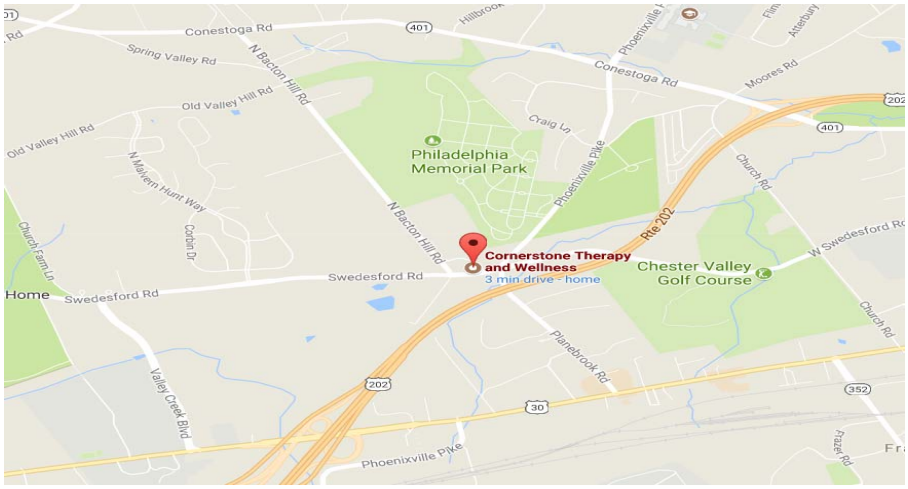
I authorize the exchange of my personal health information (PHI) regarding my clinical care needed to coordinate treatment with my primary care physician. I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that this consent expires automatically as described below. Information to be released includes diagnosis, treatment procedures and details of my condition which help to coordinate treatment. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. This release is valid for one year after last contact and I may cancel it in writing at any time.

I Do Consent: SIGNATURE(S):	DATE:
I do <u>not</u> consent to the release and exchange of any information regarding my clinical care to my primary care physician.	
I Do <u>Not</u> Consent: SIGNATURE(S):	DATE:

Directions:

Malvern Location: 639 Swedesford Road, Malvern, PA 19355

We are located in the Swedesford Corporate Center on the corner of Phoenixville Pike and Swedesford Road. As soon as you pull in the parking lot off of Swedesford Road, our entrance is located directly on the front left-hand side of the building.



Wayne Location: 996 Old Eagle School Drive, Suite 1105, Wayne, PA 19087
(When entering address in google maps, Waze or any other GPS device, please include the suite #)

Our entrace is located off of Devon Park Drive (Evolve West corporate center). As soon as you pull into the parking lot drive past our building (996) and make a right after the first speed bump. Our entrance is the second entrance on the right hand side. (Letter G and Suite 1105 located on outside glass door)