Welcome to Cornerstone Counseling of Palm Beach! We are excited about assisting you on your journey towards healing and wholeness. If you are new to the working with us, please be sure to fill out the following forms, and bring them to your first session. This will help ease you in and allow as much time as possible to focus on you.

Also, please visit our client portal at www.therapyappointment.com. Here, you can schedule or cancel appointments, update personal information, review your account, pay bills, and send secure emails to your therapist.

See Forms Below…

Cornerstone Counseling of Palm Beach Informed Consent

CONFIDENTIALITY: Everything you say is these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required by law. _____ **Initial**

WHEN DISCLOSURE IS REQUIRED BY LAW: Disclosure is required or may be required by law when there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, or to property, or is gravely disabled; or when a family member communicates to me that the client presents a danger to others. Disclosure may also be required by the courts. I will not release records to any third party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client. _____ **Initial**

EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet. _____ **Initial**

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier. _____ **Initial**

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for at least 7 years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment. _____ **Initial**

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call us at (561)-472-0397. If we do not answer, we will return your call as soon as possible. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call 911 or go to your nearest emergency room. _____ **Initial**

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. I want you to be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also

know that while we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include, behavioral, cognitive-behavioral, cognitive, psychodynamic, solution-focused, system/family, developmental (adult, child, family), or psycho-educational. I do not prescribe drugs.

_____ **Initial**

TREATMENT PLANS: On approximately your second visit, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask and I will explain it to you. You also have the right to ask about other treatments for your condition and their risks and benefits. _____ **Initial**

TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In that a case, I will give you a number of referrals whom you can contact. If at any point during therapy you are non-compliant, I will terminate treatment. In such a case, I will give you a number of referrals that may be of help to you. Upon your request, I will provide her or him with the essential information needed. You have the right to terminate therapy at any time. _____ **Initial**

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are unavoidable. I will never publicly acknowledge working with you without written permission. I will not accept you as a patient if I feel a significant dual or multiple relationship exists. It is your responsibility to advise me if any dual or multiple relationship becomes uncomfortable for you in any way. I will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare. You may do the same at any time.

_____ **Initial**

COURT TESTIMONY: The goal of psychotherapy is the reduction of stress and interpersonal conflict. Additionally, by starting treatment, you are agreeing not to involve me in legal proceeding or attempt to obtain treatment records for legal or court proceedings. In the event that I'm required to provide treatment records or testimony in any legal proceeding, you will be charged $150 per hour for any preparation time I or other personnel spend getting ready to appear or turn over documents. You are agreeing to pay $750 per 4-hour block of time that I spend being "on call" to testify, traveling to and from court/deposition, waiting to appear, and/or testifying. The minimum charge will be for 4 hours of time and subsequent time will be billed in 4-hour blocks. The initial $750 is due in full one week prior to any scheduled court appearance/ depositions. _____ **Initial**

SOCIAL MEDIA: I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or

communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites. _____ **Initial**

I have read the above policies. I understand them and agree to comply with them:

Client's Signature _____ **Date** _____

Therapist's Signature _____ **Date** _____

CONSENT TO TREATMENT OF A MINOR

I, (print name) _____,

am the (circle one) MOTHER FATHER LEGAL GUARDIAN

of _____,

and I authorize Cornerstone Counseling of Palm Beach(CCPB) to provide psychotherapy to said minor.

I also agree to be legally responsible for any charges said minor may incur during

therapy at CCPB _____ (initial here)

_____ **Date:** _____
Signature of parent or guardian

_____ **Date:** _____
Witness

FINANCIAL POLICY AND MISSED APPOINTMENT POLICY

Welcome to Cornerstone Counseling of Palm Beach! Please read over our Financial and Missed Appointment Policy. If you have questions, feel free to ask.

FINANCIAL POLICY

Fees. Counseling sessions are 45 minutes long. The fee for a 45-minute session, either face-to-face or by phone/video conference, is $135. Payment is collected at the first of the session. We also ask you to place a credit card on file for future billing.

Charges. Occasionally there are extra charges or other altered charges, but in your case the fee for a 45-minute session will be _____.

Insurance Patients. If you have health insurance, Cornerstone Counseling of Palm Beach will contact your insurance company and verify your insurance benefits. We will also file your insurance for you. If your insurance covers a portion of your therapy, we will wait up to 90 days for your insurance to pay their portion. You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.

Self-Pay Patients. Patients without insurance, with high deductibles, or who choose not to use their insurance are responsible for the cost of care. Payment is expected at the time of service.

Methods of Payment. Cornerstone Counseling of Palm Beach accepts cash, checks, and major credit cards.

Counseling Packages. You can also get a tremendous value by investing in a package of 5, 10, or 15 counseling sessions in advance. Counseling packages include individualized bonuses.

MISSED APPOINTMENT POLICY

Twenty-four hour notice is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged a fee of $60. Appointments missed because of inclement weather will not be charged. The charge will be applied to your credit card on file.

I have read and agree to the above conditions.

Name _____ Date _____

CREDIT CARD GUARANTEE

[ ] SELF-PAY PATIENTS

If you:

- Are uninsured
- Have insurance that does not cover the cost of mental health counseling,
- Or choose to pay out-of-pocket for other reasons,

then you are responsible for full payment at the time of services. As a convenience to you, we will automatically charge your designated card below on the day of services.

We charge a **missed appointment fee** of ________________ in the event that you miss an appointment without giving **24-hours' notice**.

[ ] INSURANCE PATIENTS

You are responsible for meeting your **deductible** and making **co-pays** or **co-insurance** payments at the time of service. As a courtesy to you, we will bill your health insurance provider on your behalf for the balance and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment.

On Day 90, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims thereafter will be immediately refunded to you.

Your insurance provider does not pay for missed appointments. If you miss an appointment without giving **24-hours' notice**, you will be charged a **missed appointment fee** of _____________.

I agree to the above terms and authorize you to charge my card.

____ ____________________

SIGNATURE DATE

- -

CREDIT CARD: ❒ AMEX ❒ VISA ❒ MC ❒ DISCOVER

CARDHOLDER'S NAME ____

BILLING ADDRESS ____

____

CARD # ___________________________________ EXP. DATE __________

THREE DIGIT CID NUMBER _________

Health Insurance Portability Accountability Act (HIPAA)

Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or

services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

· ***For Treatment –*** We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
· ***For Payment*** – We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Informed Consent and Financial Policy.
· ***For Operations*** – We may use and disclose your health information within Cornerstone Counseling of Palm Beach as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Patient's Rights:
· ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
· ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

· ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

· ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

· ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.

· ***Right to a copy of this notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.

· ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

· ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.

· ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.

· ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

· ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

_____ _____

Therapist Signature Date

_____

Therapist Printed Name, Credentials