

# Cornerstone Counseling

Whitehall Location: 516 E. Colby St. Whitehall, MI 49461  
Muskegon Location: 2052 E. Apple Ave. Muskegon, MI 49442  
(231)-893-8336

## Consent for Treatment / Adult

**Welcome:** to Cornerstone Counseling. The decision to enter therapy is an especially important one and at Cornerstone Counseling, we want to provide a safe and welcoming environment for all our clients. We have put together this information sheet to inform you of our policies so that you will have the information necessary to make the time here beneficial and to reduce any anxiety you may have about therapy. We believe in providing you with quality, scientifically based service. If it appears that you would receive a particular benefit from a different type of intervention that we are not trained to provide, we will facilitate the referral that will best meet your needs. If you have further questions about any of the issues addressed, please discuss them with your therapist prior to beginning treatment or disclosing any information about yourself.

### Limits of Confidentiality

**Confidentiality:** By law and professional ethics, what you share with us as your consultant, remains confidential unless we have your permission to share it with a third party. We follow all laws and policies concerning confidentiality. No information is released without your written permission except for a situation in which you or another person is in immediate danger. If you wish for us to communicate with a third-party about your situation, we ask you to sign a Release of Information form, which we keep in your casefile. Please refer to our Notice of Privacy Practices for details. Please be aware that your therapist may discuss your case in supervision with other professionals and will make every effort to protect your confidentiality and identifying information. Please note that when you sign our Consent for Treatment form you are allowing us to bill your insurance company for your treatment. Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

#### **Duty to Warn and Protect:**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

#### **Abuse and/or Neglect of Children and Vulnerable Adults:**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

#### **Prenatal Exposure to Controlled Substances:**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

#### **Minors/Guardianship:**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

#### **Insurance Providers: (when applicable)**

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to; types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

# Consent for Treatment

**Contacting Us:** Your care is important to us. Every possible effort to return your call or respond to a message will be made in a timely manner. We utilize a confidential answering machine on our business phone, (231)-893-8336. If your situation is an emergency, please call 911 or go to your local emergency room.

**Emergencies (Unscheduled Requests for Consultation):** Most of the providers may be reached via cell phone in the case of an emergency. While we are available by telephone, we do not maintain a consultant "on-call" to meet with you outside of normal business hours because we also attempt to maintain a healthy personal and family life for ourselves. If a situation is sufficiently serious for you (or one of our consultants) to fear impending harm to yourself or others, we will ask you to immediately use one of the following options, depending on the situation:

1. Contact supportive family or friends.
2. Call the local Help Line in Ottawa County (616)-842-4357 / Muskegon County (231)-722-4357
3. Request local police support by calling 911.
4. Go to the nearest Hospital Emergency Room

**Regular Fee Schedule:** Fees for the service provided are \$175.00 - \$200.00. **If subpoenaed or requested to a court trial, mediation, or other out of office event; insurance does not pay for this service. This payment will be made out-of-pocket by the client. \$450.00 fee per hour will be charged plus travel time.**

**Letters, Forms and Other Correspondence:** If you request a letter, form, or other type of correspondence to be completed by your counselor, you will need to sign a Release of Information as previously stated. Charges for their time will be billed at \$50 per quarter hour.

**Attendance and Cancellation Policy:**

If you fail to cancel a scheduled appointment without a 24-hour notice, you will be billed \$50. An appointment will be considered missed if you arrive 15 minutes or later, past the appointment time. Please note 3 missed appointments will result in termination of services through our office.

**Please initial here:** \_\_\_\_\_

**Account Balances:**

Most insurance companies do not cover 100% of charges. You are expected to pay your co-pay and /or deductible at the time of service. If there is a balance on your account when you call to schedule, your balance must be paid in full before we can schedule another appointment. **Please initial here:** \_\_\_\_\_

**Consent:**

By signing below, you voluntarily consent to treatment and understand that no guarantees have been made as to the results. You express understanding of the above information and consent to treatment based on the limitations described. You understand that it is your responsibility to inform your counselor of any changes in physical or mental condition. Please seek clarification of any questions you have prior to signing.

**Print Client Name:** \_\_\_\_\_

**Signature of Client or Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Cornerstone Counseling

## Client Intake Information

How did you hear about us?  Referred by: \_\_\_\_\_  Internet  Sign  Other

Name of Client: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female S.S. #: \_\_\_\_\_

Client's Occupation or Student: \_\_\_\_\_

Place of Employment or School Attending: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Cell/Other Phone: \_\_\_\_\_ May we leave a message?  Yes  No Is it ok to text you?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please note: Email/texting correspondence is not considered to be a confidential medium of communication.

Marital Status:  Single  Dating  Married  Separated  Widowed  Divorced If married, how long? \_\_\_\_\_

Partner's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\*If you wish for us to coordinate care with your Physician, please be sure to fill out a release of information form.

Family Members: For Adults, list Spouse & Children / For Children, list Mother, Father & Siblings

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_ Living at home?  Y  N

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_ Living at home?  Y  N

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_ Living at home?  Y  N

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_ Living at home?  Y  N

Name of anyone else living in the home: \_\_\_\_\_

I plan to pay out-of-pocket: (If so, please put N/A in the required insurance fields below)

I plan to use an Insurance policy: (If so, please fill in the required fields below)

Name of Insurance: \_\_\_\_\_ Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Secondary Insurance?  No  Yes, \_\_\_\_\_

### PRESENTING PROBLEM(S)

Please state in your own words the reasons for which you are requesting counseling.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*I agree that it is my responsibility to call my insurance company to determine insurance benefits and obtain authorization if needed. I will take responsibility for any charges not covered by my insurance policy.

\*I authorize the release of any medical or other information necessary to process insurance claims.

\*I authorize payment of medical benefits directly to the provider for services rendered.

\*I agree to be financially responsible for all charges incurred at this office including my insurance deductible, co-payment and any services rejected by my insurance company.

Signature of Client or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

1. Have you previously received any type of mental health services?  
 No  Yes, previous therapist/practitioner: \_\_\_\_\_
  
2. Are you currently taking any prescription medication?  No  Yes  
Please list: \_\_\_\_\_  
\_\_\_\_\_
  
3. Have you ever been prescribed psychiatric medication?  No  Yes  
Please list and provide dates: \_\_\_\_\_  
\_\_\_\_\_
  
4. How would you rate your current physical health? (Please check the box)  
Poor  Unsatisfactory  Satisfactory  Good  Very good   
If any, please list specific health problems you are currently experiencing:  
\_\_\_\_\_
  
5. Are you currently experiencing overwhelming sadness, grief, or depression?  No  Yes  
If yes, for approximately how long? \_\_\_\_\_
  
6. How often do you engage in alcohol use?  Daily  Weekly  Monthly  Infrequently  Never
  
7. How often do you engage in recreational drug use?  Daily  Weekly  Monthly  Infrequently  Never
  
8. Are you currently in a romantic relationship?  No  Yes If yes, for how long? \_\_\_\_\_  
On a scale where "1" indicates strongly dissatisfied and "10" indicates very satisfied,  
how would you rate your relationship? \_\_\_\_\_
  
9. Do you consider yourself to be spiritual or religious?  No  Yes  
If yes, describe your faith or belief: \_\_\_\_\_  
\_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY:**

In the section below identify if there is a family history of any of the following:  
(Parents, Siblings, Uncles, Aunts, and Grandparents):

Please check the box, then list family member's relation:

- |                         |  |       |
|-------------------------|--|-------|
| Alcohol/Substance Abuse | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Anxiety                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Depression              | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Bipolar Disorder        | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Domestic Violence       | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Eating Disorders        | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Criminal History        | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Schizophrenia           | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Suicide Attempts        | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |

# Symptom Checklist

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please read each item below and determine which statement is true for you. Then, check the appropriate box to indicate how often you feel the statement applies to you during the *past three months*.

	None or little of the time	Some of the time	Most or all of the time
Wake up at night or in the early morning and unable to return to sleep			
Very restless sleep			
Cannot get to sleep			
Decreased need for sleep			
Loss of energy			
Unable to enjoy life; have lost a zest for life			
Have withdrawn from others			
Loss of appetite			
Weight loss (How much in past month? ____ lbs) Weight gain (How much in past month? ____ lbs) Have you been trying to diet?			
Increased sex drive			
Decreased sex drive			
Increased energy			
So happy that people describe me as "manic"			
Palpitations or rapid heartbeat			
Sudden episodes of nervousness or panic			
Fear of losing self-control			
Ready to explode			
Shortness of breath			
Strange or unusual thoughts			
Hallucinations, hear voices, or see things that are not there			
Very peculiar experiences			
Excessive use of alcohol/drugs			
Thoughts about harming someone			
Strong thoughts about suicide			

# Cornerstone Counseling

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS HANDOUT CAREFULLY.**

### **UNDERSTANDING THE TYPE OF INFORMATION WE HAVE:**

We get information about you when you choose to enter treatment. It includes your date of birth, sex, identification number and other personal information. We may get reports from your doctor and other data about your medical care.

### **OUR PRIVACY COMMITMENT TO YOU:**

We care about your privacy. The information we collect about you is private. We are required to give you a notice of our privacy practices. Only people who have both the needs and the legal right may see your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment, payment, business operations or when we are required by law to do so.

- **TREATMENT:** We may disclose your medical information in order to coordinate your health care.
- **PAYMENT:** We may use and disclose information so the care you receive can be properly billed and paid.
- **BUSINESS OPERATIONS:** We may need to use and disclose information for our business operations. For example, we may use information to review the quality of care you get.
- **EXCEPTIONS:** For certain kinds of records, your permission may be needed even for release of treatment, payment, and business operations.
- **AS REQUIRED BY LAW:** We will release information when we are required by law to do so.
- **WITH YOUR PERMISSION:** If you give us permission in writing, we may use and disclose your personal information. You also have the right to change your mind and revoke it in writing.

### **YOUR PRIVACY RIGHTS:**

You have the following rights regarding the health information that we have about you.

- **YOUR RIGHT TO INSPECT AND COPY:** In most cases, you have the right to look at or get copies of your records. You may be charged a fee for the cost of copying your records.
- **YOUR RIGHT TO AMEND:** You may ask us to change your records if you feel that there is a mistake. The request may be denied; and a written reason for the denial will be supplied.
- **YOUR RIGHT TO A LIST OF DISCLOSURES:** You have the right to ask for a list of disclosures that have been made concerning your records. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to your or your family, or information that was sent with your authorization.
- **YOUR RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS:** You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You do not have to explain the basis of your request.

### **CHANGES TO THIS NOTICE:**

We reserve the right to revise this notice. We are required by law to comply with whatever notice is currently in effect.

I have received a HIPPA form describing how personal and medical information may and may not be disclosed, and how I can get access to information. Please sign below.

**Signature of Client or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## INFORMED CONSENT TO TELEHEALTH

Telehealth allows my therapist to diagnose, consult, treat, and educate using interactive audio, video, or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with my provider at Cornerstone Counseling.

**Client Name:** \_\_\_\_\_

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I understand that by utilizing this teletherapy service, the client agrees that the "point-of-service" of therapy is to occur in the therapist's state of licensure, not the clients. It is my policy to inform clients that they are receiving services from my office (as if they were physically traveling to my office in Michigan) and therefore are bound by the laws of the State of Michigan. These laws are primarily related to confidentiality as outlined in this form and my Consent for Services and other intake forms. In essence, the client is using the telephone or the Internet to virtually travel to the therapist (the therapist's state of professional licensure). By agreeing to utilize the therapist's services, the client agrees to these terms. If you do not understand, or have any questions regarding this issue, please feel free to ask me about this issue.

I understand that some insurance policies exclude telehealth sessions and that any coverage information provided is just an estimate. I will be responsible for any telehealth sessions that are not covered by my insurance.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to Cornerstone Counseling. My signature below indicates that I have read this Agreement and agree to its terms.

\_\_\_\_\_  
**Authorized Signature of Client or Guardian**

\_\_\_\_\_  
**Date**

