Cornerstone Clinic, LLC
631 E. Crawford Street *Suite 209
Salina, KS 67401

*Jenna Krehbiel, MSW, LSCSW, RPT/S *Lydia Lund, MSW, LMSW *Kelly Hopkins, MSW, LMSW
*Katie Herwig, MSW, LSCSW, LCAC

NEW CLIENT PACKET:
INFORMATION REGARDING POLICIES AND SERVICES

INFORMED CONSENT AND AGREEMENT TO PSYCHOTHERAPY

PLEASE READ THOROUGHLY, MAKE A NOTE OF QUESTIONS YOU MAY HAVE. PLEASE CONTACT YOUR THERAPIST DIRECTLY TO DISCUSS.

AFTER YOU SIGN THIS AGREEMENT, YOU WILL HAVE A HARD COPY FOR YOUR RECORDS. We will store a copy of this signed agreement in a highly confidential, HIPAA compliant, encrypted, electronic cloud storage system along with the rest of your clinical file.

ABOUT CORNERSTONE CLINIC, LLC AND YOUR THERAPIST

CORNERSTONE CLINIC, LLC is a limited liability company in the state of Kansas located at 631 E. Crawford Street, Suite 209; Salina, KS 67401. This company provides psychotherapy and counseling services as well as educational and support services for children and adults.

All therapists at Cornerstone Clinic, LLC are fully licensed in the state of Kansas and participate in appropriate supervision and peer consultation as well as ongoing continuing education.

BENEFITS OF PSYCHOTHERAPY

Depressed mood can be lifted, managed, and alleviated. Anxieties can be managed, mastered, and alleviated. Through talk (or for children, play) difficult feelings can naturally be resolved. Skills in relationships and communication improve. Through psychotherapy, one may develop and maintain a sense of balance in life, contentment, satisfaction, and skills for coping through life's challenges. Clarity of direction in and sense of self develops. One may experience relaxation and relief from mental and physical tension.

RISKS OF PSYCHOTHERAPY

Occasional uncomfortable levels of sadness, guilt, anxiety, frustration, loneliness, helplessness, or other negative feelings as a part of the process of healing and finding balance. Often symptoms worsen before improving. Unpleasant memories may be recalled through the process. Significant others in one's life may have their own objections or negative reactions to a client's positive changes.

Overall, the benefits greatly outweigh the risks. When you and your therapist are both committed to the process of psychotherapy, with understanding it is not a "quick fix," transformational results are often observed.

In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of our profession. There are some exceptions as follows:

LIMITS TO CONFIDENTIALITY

1) If you make a serious threat to harm yourself, the law requires your therapist to try to protect you by informing appropriate officials.
2) If we have reason to believe a child or any dependent adult has been or will be abused or neglected, we are legally required to report this to the proper authorities.
3) If you are or will be involved in court proceedings and the clinical record is subpoenaed and ordered by a Judge.
4) If a guardian ad litem (GAL) is appointed in a court case involving child clients and she/he is ordered by the court to have access to mental health practioners and records therein.
5) The Patriot Act of 2001 requires us in certain circumstances, to provide federal law agents with records, papers, and documents upon request and prohibits us from disclosing to my client that the FBI sought or obtained the items under the Act.
6) In professional supervision or consultation with other therapists and/or business associates; shared office space; records storage and voicemail system with a fellow therapist. Professional peers, business associates, fellow therapists and any supervisor are bound by confidentiality as well.
7) As a clinical professional and associate professionals we often need to consult with a professional supervisor and/or a professional peer on the services we are providing you in order to ensure you are receiving the best services possible. This may include details of your case and in this age of electronic technology it may mean that this information is shared via cell phone conversations. All professional peers and supervisors are bound by the same legal and ethical rules of confidentiality. We do not disclose your name, or identifying information unless it is a case of imminent emergency and/or involves DCF.
8) Tele-health, including electronic communications, includes limitations of your confidentiality. Email, texting, and cell or Google voice phone communications cannot be guaranteed confidential. These means of electronic communication are considered "non-secure." (See section on Tele-Health).
9) In the case of death or incapacitation, all clients will be contacted and records will be accessed by a designated mental health professional who will ensure confidentiality.
10) In the case we need to collect unpaid payments, a collection agency may be utilized.

TELE-HEALTH AND YOUR CONFIDENTALITY

In this age of electronic communication we are required to be very clear with our clients as to the nature of the risks and benefits of "tele-health." Any time you and we communicate in a way that cannot be guaranteed as secure in maintaining your confidentiality, there is a risk involved. There are limits to your confidentiality when participating in any form of "tele-health."

Tele-health is defined by the U.S. Department of Health and Human Services as: The use of electronic information and telecommunications technologies to support distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include video conferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

In order to make every effort to keep secure the confidentiality of your Private Health Information please note the following specific policies of Cornerstone Clinic, LLC:

EMAIL POLICY:

We may use email to send and receive informed consent, reduced fee applications, and other formal documentation through a HIPAA compliant system. Email, however, cannot be guaranteed a secure means of address to transmit and receive documents. You may choose to forego this electronic system, print off this document fill it out by hand and bring a hard copy with you to your first session. Otherwise, use of email should be for scheduling/payment issues only. You may email us about

anything you wish but please understand that by doing so you are accepting the risk and limit of your confidentiality by using email.

If you wish to use email as part of your counseling, you may utilize www.hushmail.com as they have an encryption process. Discuss this with your therapist first. There is a charge for time spent reading emails that go beyond brief exchanges about scheduling and payment issues. Please see attached fee outlines.

TEXTING POLICY:
Texting ideally should be used for brief notification regarding scheduling or notification of running late for appointment. Therapists' phones are protected with passwords, but texts may show up when the screen is locked which may be a breach of your confidentiality. If you choose to use texting to communicate sensitive information you do so with full knowledge and acceptance that this is a risk and limit of your confidentiality. We do not participate in therapeutic discussions with clients via text messaging.

PHONE POLICY:
Cell phone communications cannot be guaranteed as a confidential form of communication. The only method HIPAA acknowledges as a secure way to have phone conversation is when both parties are talking on a landline phone that is hard wired from handset to wall. In this day and age, we would all be hard pressed to find way to have that kind of phone conversation. We do utilize cell phone technology as most of our clients do as well. We make every effort to ensure our phone conversations are held confidential within our ability to do so. When we have a conversation via cell phone, you are acknowledging and accepting the risk and limits of your confidentiality. If you don't wish to take this risk, we advise you only use phone communication to schedule an appointment in person to discuss sensitive information as part of your Private Health information. Phone therapy sessions are available with some of our therapists. Please discuss this with your therapist if you are interested in participating in distance therapy services.

VOICEMAIL POLICY:
Per the above policy regarding cell phone use, please be informed that our voicemail systems are housed on cellular and internet basis and cannot be guaranteed confidential, although we take every measure to protect your confidentiality. It is advised that you not leave sensitive information on voicemail, rather utilize voicemail to request a return call and/or to schedule an in-person appointment. Voicemail is password protected and secure to the best of our ability. Voicemail is checked throughout the week unless on vacation or out of country for any reason. We are accessible Monday-Friday during normal business hours (8am-6pm) and we make every attempt to return all calls within the same business day if possible. When not possible, we return all calls within three business days. Therapists are not available when in session with other clients. When away from the office and unable to access voicemail, your therapist will notify you in advance and will designate a professional therapist colleague to be on call in case of urgent issues.

SOCIAL MEDIA POLICY:
In order to protect your confidentiality, and in line with our professional ethics, we cannot accept friend or connection requests from clients on any social media platform. You may follow social media accounts that are open to the public but please do not comment or in any way identify yourself as a client of Cornerstone Clinic, LLC. If you do you are accepting the risk of breach of your confidentiality and if we notice you have commented on any public post, your comments will be deleted.

PUBLIC/SOCIAL INTERACTION:
In the case we cross paths in a public setting, in order to protect the confidentiality of our therapeutic relationship, it is our policy not to approach you or initiate contact with you.

POLICY ON CONFIDENTIALITY OF MINOR CLIENTS:
In working with child clients (though legally the parent or legal guardian of child) age appropriate privacy is essential relationship and setting for a child's therapy, we do honor what the child does or says in our sessions as confidential while providing parents and /or legal guardians summaries of treatment goals, plans, and progress as well as recommendations.

POLICY ON SCHEDULING AND CANCELLATIONS
(*Please also refer to Fee for Services Agreement)
We require 12 hours texted or email notice of cancellation of any appointment. If a client does not arrive for a scheduled appointment or cancels within 12 hours of appointment, there will be a charge of $55. On rare occasion, if there is what we determine to be an unavoidable emergency you may discuss this with your therapist and we may consider waiving the fee.

Session parameters:
Initial Intake Session is 60 minutes
Individual Therapy Sessions are 45-60 minutes *this may be dictated by your insurance company
Couples counseling and family counseling sessions are 45-50 minutes
Sessions start and end on time.

VACATION/TRAVEL POLICY:
When away from the office for vacation or business travel, and unable to access voicemail and/or email, your therapist will notify you in advance and will designate a professional therapist colleague to be on call in case of urgent or emergent issues.

POLICY on CONFIDENTIALITY WITH COUPLES AND FAMILIES:
In couples or family therapy, the couple as an entity and the family as an entity is the client although one individual may be deemed the "identified client" for record keeping and insurance reimbursement purposes. Our policy is that we are not providing individual therapy for any individual in the couples or the family although sessions with individual in the couple/family may be a part of the couples/family therapy. We will not be a "secret keeper" nor facilitate secret keeping. If anything significant is revealed in an individual session that your therapist feels the other party needs to be told, your therapist will require it be brought up in the next session together so we can work through it or counseling may have to be ended with a referral to another therapist.

POLICY on DIVORCE and/or CUSTODY CASES:

We are NOT custody evaluators and cannot make any recommendations on custody. We can refer you to a licensed professional who DOES provide custody evaluation if needed. Due to the sensitive nature of divorce and all potential issues that arise in such cases, we have very specific policies to which you must agree before we enter a counseling relationship:

1. We require a copy of any most current standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the Judge at the intake session.
2. In most cases, we need to have contact and written/signed consent with/from both legal guardians before we see the child for counseling. In the case there is a final decision maker on health related issues who wants the child to be seen for therapy, even in the case the other parent does not agree, it is to the discretion of your therapist as to whether the child will be seen.
3. We will provide an interview with any court ordered Guardian ad Litem (GAL) and/or custody evaluation (CE) whom the court has ordered will have access to the child's records and any time spent speaking with the GAL or CE will be billed to and paid by you, the client at our court-related fee hourly rate.
4. We will be in equal contact with both parent who share in the legal custody of the child being seen for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.
5. Family sessions may be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.
6. We require all clients waive right to subpoena any of our therapists to court. By signing this agreement you are acknowledging and agreeing NOT to have us subpoenaed to court. This policy is set in order that we can preserve the integrity of the therapeutic progress and relationship with you and/or your child (ren). There are exceptions to this and we can discuss further should the issue arise and this policy needs to be waived.
7. In the case the above policy regarding subpoenas and court is waived (or disregarded) and we are subpoenaed to appear in court-even with a waiver of this policy-you will be billed for the full standard fee for Court Related work of $200/hour for all professional time. Any time dedicated to any court-mandated appearance including preparing documentations, discussions with lawyers and/or the GAL in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at $200/hour. Any reduced fee granted will not apply to court related work.

FEES, PAYMENT, INSURANCE:

We are dedicated to making therapy services affordable for you and your family. Regardless of whether we are in network with your insurance company or not, we WILL work with you with respect to your financial situation. If we are not in network with your insurance company it is our policy that we do not communicate directly with insurance companies. We can, however, provide a statement for you to file with your insurance company for out of network reimbursement upon request.

You are responsible for keeping track of your session statements and filing with your insurance.

Reduced fees are available with application and are extended based on financial need and circumstances.

RETURNED CHECK FEE:
There is a $30 fee for any returned checks. That fee is due at the time of your next session, along with the payment for that session. If a check is returned for insufficient funds, we will require that you pay using cash or credit card only from that point forward.

FORMS OF PAYMENT:
We accept debit and credit card. Checks should be made to "Cornerstone Clinic, LLC." Cash is welcome as well. A receipt is available to you upon request. Payment is due at the beginning of each session. If a child client is being seen, please be discreet in submitting payment and we ask that you never have the child involved in the payment process.

FEE FOR SERVICES:

Standard Fee Structure for Licensed Therapists:

Initial Intake Session (60 minutes) $200

Couples or Family Therapy Sessions (50 minutes) $175

Therapy Session (45-60 minutes) $175

Tele-health Session (30 minutes) $50

Student Interns:

Initial Intake (60 minutes) $75

All other therapy sessions (45-60 minutes) $50

Other Fees Charged by All Therapists:

Email Counseling (anything other than brief updates and document exchange that requires writing or reading more than 10-15 minutes of time): $40

Preparation of Summaries of Treatment or Letters at request of client: $ 40 per item requested

Court Related and/or Child Specialist Work for Collaborative Law Cases: $150/hour of any and all time spent on the case.

Administrative Fee for Record Copy Requests: $25 and $10/page after initial 20 pages.

Check Return/Insufficient Funds Fee: $30

AFTER HOURS AND EMERGENCY SUPPORT:
Cornerstone Clinic, LLC is not an emergency services agency. We do not provide emergency services.

If you have a life threatening emergency you should call 911 or go to the local hospital emergency room of your choice. Only contact us in an emergency after you have already obtained emergency assistance from 911 or your choice of medical support.

Other after hour Mental Health Resources (not to be substituted for calling 911):
You may call or text your therapist and follow instructions.

YOUR CLINICAL RECORD:
You should be aware that, pursuant to HIPAA, we keep information about all clients in a collection of professional records. This constitutes your Clinical Record. We store your clinical records in a HIPAA compliant electronic cloud storage location.

If you want to have a copy of your clinical record: There will be an administrative fee of $100 charged for preparing the records for release upon your written request.

COMPLAINTS or GRIEVEANCES:
If you feel that there is basis for formal complaint or grievance about anything related to the psychotherapy we provide, we request you to first communicate your concerns to us directly so that we will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about your therapist and may do so by contacting the board at the following address and phone number:
Kansas Behavioral Sciences and Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603
(785) 296-3240

FEE FOR SERVICE AGREEMENT

Please note, your entire record including this form is stored on HIPAA compliant electronic server.

Every time I ___________________________(client name) schedule an appointment with my therapist I Understand that I am entering into a contract with Cornerstone Clinic, LLC and for the professional time and services of my therapist.

I recognize that professional services include time and services for preparation for my scheduled session, the actual time in session, time spent outside of session with case review, case notes, confidential consultation or supervision as outlined above.

I understand my therapist's professional fees as outlined in our Agreement to Enter Into Psychotherapy Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time.

I understand that Cornerstone Clinic, LLC has a cancellation policy requiring no less than 12 hours advance notice in order to be released from the contract for my therapist's time and services of preparation for my session.

I understand and agree that if I fail to cancel my appointment inside of the 12-hour minimum time period prior to my session I will be charged a full session fee for the appointment. This fee is not billed to insurance and you are responsible.

I hereby authorize Cornerstone Clinic, LLC to charge my Credit/Debit Card on file for any missed sessions or unpaid charges per this contract. I understand my credit/debt card will be stored in triple encrypted merchant services system for my protection.

I understand if there is an emergency situation that prohibits me from canceling within 12 hours, I can discuss this with my therapist directly and request a waiver of this policy but I understand that Cornerstone Clinic, LLC and my therapist are not bound to grant that waiver and may, by this contract, proceed with charging my credit card as agreed herein.

I understand if payment is not made before or during my scheduled session, I am hereby authorizing Cornerstone Clinic, LLC to charge my afore-listed credit card for services rendered.

I understand this agreement authorizes Cornerstone Clinic, LLC to charge my credit card for services requested and rendered outside of the office such as email counseling, phone sessions, preparation of documents requested by me or any court related proceedings.

HIPAA Privacy Policy
Cornerstone Clinic, LLC

Privacy Protection Notice:
THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. A PAPER COPY IS AVAILABLE IN OUR WAITING ROOM FOR YOUR REVIEW AS WELL.

I. **Your rights to Privacy under HIPAA Preamble:** Communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defies what kind of information is to be included in your Designated Medical Record, as well as some material, known as Psychotherapy Notes, which is not accessible to insurance companies and other third-party reviewers and in some cases not to the client himself/herself. HIPAA provides privacy protections about your personal health information, called protected health information (PHI), which could personally identify you. PHI consists of three components: treatment, payment, and health care operations. Treatment refers to activities in which I provide, coordinate, or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, testing, or talking to your primary care physician about your medication or overall medical condition. Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you. Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is really medically necessary. The use of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records, and other tasks within my office related to your care. Disclosures refer to activities you authorize which occur outside my office such as the sending of your protected health information to other parties (i.e. primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization
The law requires authorization and consent for treatment, payment, and healthcare operations. I may disclose PHI for the purposes of treatment, payment, and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e. file insurance for you). Additionally, if you ever want me to send any of your PHI of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might by your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so. There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapists –client in treatment settings, HIPAA permits separate "psychotherapy

notes" separate from the overall "designated medical record." Insurance companies cannot secure psychotherapy notes nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. Psychotherapy notes are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, or joint family counseling session and separated from the rest of the individual's medical record. Psychotherapy notes are necessarily more private and contain much more personal information about you, hence, the need for increased security of the notes. Psychotherapy notes are not the same as your progress notes, which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological testing, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record." You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I ensure that all those performing ancillary administrative service for my practice and refers to these people as "Business Associates" sign and enter into a HIPAA compliant Business Associate Agreement so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:
-Child abuse
-Suspected sexual abuse of child
-Adult and domestic abuse
-Health Oversight Activities (i.e. licensing board for Social Workers in Kansas)
-Judicial or Administrative Proceedings (i.e. if you are ordered here by court)
-Serious Threat to Health or Safety (i.e. our "Duty to Warn" law, natural security threats)
-Worker's Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer)
I never release any information of any sort for marketing purposes.

V. Client's Rights and Duties

You have a right to the following:

The right to request restrictions on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;

The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;

The right to inspect and receive a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;

The right to amend material in your protected health information, although I may deny an improper request and/or respond to any amendments you make to your record of care;

The right to an accounting of non-authorized disclosures of your protected health information

The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and

The right to revoke your authorization of your protected health information except to the extent that action has already been taken. For more information on how to exercise each of these aforementioned rights, please do not hesitant to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointments. My duties as a Licensed Clinical Social Worker on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executive private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

VI. Complaints

Jenna Krehbiel is the appointed "Privacy Officer" for Cornerstone Clinic, LLC per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to speak to Jenna immediately about this matter. You will always find us willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

HIPAA provides client protections related to the electronic transmission of data (the transaction rule), the keeping and use of client records ("privacy rules"), and the storage and access to health care records ("the security rules").

HIPAA applies to all health care providers, including mental healthcare, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords us all. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to

protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitant to ask me for further clarification By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document.

Cornerstone Clinic, LLC
Jenna Krehbiel, MSW, LSCSW, RPT/S

I, ____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

____
Client Signature OR Parent of Minor or Legal Guardian

Date: _________________________

AGREEMENT TO ENTER INTO COUNSELING SERVICES AND ABIDE BY FEE AGREEMENT AND ALL POLICIES HEREIN

_____ I have read or had read to me all the information in New Client Packet.

_____I have had a chance to review and ask questions about all and any information in this New Client Packet before signing this agreement.

_____I have had all questions answered to my satisfaction prior.

_____I agree to abide by all the policies outlined herein including my full agreement not to have Cornerstone Clinic, LLC, or my therapist subpoenaed by myself or any attorney I may employ.

By signing this agreement, I am consenting to treatment; understand all the benefits and risks of counseling as outlined herein. I also hereby acknowledge that I have received and reviewed the HIPAA Privacy Policy notice form mentioned herein.

Name of Client or Parent/Guardian of Minor:
____

Signature of Client and/or Parent/Guardian of Child Client:
____

Date: ____

Witness Signature: __________________________________

Client Legal Name: __________________________________

CREDIT CARD ON FILE POLICY

At Cornerstone Clinic, LLC, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure in a HIPAA compliant, encrypted system. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

I authorize Cornerstone Clinic, LLC to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

___Amex ___Visa ___Mastercard ___Discover

Credit Card Number ____

Expiration Date _________/_________/_________

CVV _________

Cardholder Name ____

Signature ____

Billing Address ____

City ______________________________ **State** _____ **Zip** _____________

I (we) the undersigned authorize and request Cornerstone Clinic, LLC to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Cornerstone Clinic, LLC.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Cornerstone Clinic, LLC in writing and the account much be in good standing.

Patient Name: ____

Patient Signature (or Legal Guardian): ____

Date: ______/_______/_______

Cornerstone Clinic, LLC
Individual, Family, and Marriage Therapy
631 E. Crawford Street Suite 209
Salina, KS 67401

CLIENT'S CURRENT LEGAL NAME: ____
Last First M. Initial

ADDRESS ____

CITY________________________ STATE ______________________ ZIP__________

PHONE ______________________ BIRTH DATE _________________ SEX ________

AGE ________________________ SOC. SEC. # ___________________

MARITAL STATUS OF CLIENT: (Circle) SINGLE MARRIED DIVORCED SEPARATED WIDOWED

EMPLOYED: ___YES ___ NO OCCUPATION: ______________________________________

PLACE OF EMPLOYMENT ______________________ PHONE ________________________

CURRENT PRIMARY CARE PHYSICIAN ____________________

WHO REFERRED YOU HERE ____________________________

DOES PERSON RECEIVING SERVICE HAVE A LEGAL GUARDIAN ___ YES ___ NO

PLEASE LIST PARENT OR GUARDIAN INITIATING TREATMENT TODAY:

NAME ______________________ RELATIONSHIP ___________________ PHONE _________

ADDRESS ____________________ CITY/STATE/ZIP _________________________________

SSN ________________________ PLACE OF EMPLOYMENT ___________________________

PHONE ______________________

PLEASE LIST OTHER BIOLOGICAL OR ADOPTIVE PARENT, OR OTHER LEGAL GUARDIAN:

NAME ______________________ RELATIONSHIP ___________________ PHONE _________

ADDRESS ____________________ CITY/STATE/ZIP _________________________________

SSN ________________________ PLACE OF EMPLOYMENT ___________________________

PHONE ______________________

PLEASE CIRCLE PRIMARY SOURCE OF FAMILY INCOME: WAGES, SOCIAL SECURITY, WELFARE, RETIREMENT, DISABILITY, UNEMPLOYMENT, OTHER

INSURANCE POLICY HOLDER'S NAME ____

DOB: ____________________ PHONE ____

ADDRESS: ______________________ CITY ________________ ST______ ZIP _______________

INSURANCE COMPANY ____ ID # _______________

PLACE OF EMPLOYMENT ____ GROUP # ___________

MEDICAID # ___________________________________ MEDICARE # ______________________

***WOULD YOU LIKE TEXT REMINDERS 24 HOURS IN ADVANCE OF SCHEDULED APPOINTMENTS?

____________YES ____________NO

SIGNATURE ____________________________________ DATE ____________________________

WITNESS _______________________________________ DATE ____________________________