



Adult Intake Packet

Welcome to Cornerstone Health Counseling

Cornerstone Health Counseling is committed to treating the whole person. We provide counseling services to nurture you to become a healthy individual in body, soul, and spirit. Clinic services are provided by licensed psychologists, master level clinicians, individuals with master's degrees seeking licensure, and students in graduate programs. The students and non-licensed clinicians are under supervision by on-site clinical supervisors. Information regarding your chosen therapist's qualifications will be provided. Clinic services do not include forensic work. Court-ordered services will only be provided at the discretion of the therapist. Additional fees will be added for any court-related services. Such fees will be provided if approved. For questions about your treatment, you may call us at (907) 522-7080.

Please initial on each line, indicating that you have read the paragraph.

_____ **CONFIDENTIALITY:** We place a high value on client privacy; all records are confidential. Recording devices in session are only authorized if a prior mutual agreement between clinician and client has been established. We may bring client cases to case consultation or consult with another therapist within the agency. Should we do so, no name or other identifying information will be shared. You may give written permission for your therapist to share information with other individuals like medical or psychiatric providers, school personnel, case workers, or family members. Legal requirements specify certain conditions in which it is necessary for us to disclose your name and/or your treatment. These requirements are as follows:

- 1. If we believe you are a danger to yourself or others.**
- 2. If we become aware of any involvement you have in the abuse of children, elderly, or disabled persons.**
- 3. If we are ordered by a judge or court to release your records.**

_____ **FEES:** I understand that if my therapy hour extends over the normally scheduled time, I may be responsible for a larger co-pay or co-insurance and anything else that my insurance will not cover. Fees also apply to the preparation of assessment and other reports, telephone conversations, consultations, or meetings you have authorized as part of your counseling process. We will bill your insurance carrier(s) as a courtesy. Insurance co-pays and co-insurance are due at the time of visit. If your insurance does not pay, you are responsible for your bill. Our billing is done through Spectrum Medical Billing Services, LLC and their phone number is (907) 440-5900.

_____ **NO-SHOWS/LATE CANCELLATIONS:** If you are unable to attend scheduled session, please give us a 24-hour notice of cancellation. The fee for an unkept appointment/late cancellation is \$100. After three no-shows or late cancellations, you may be subject to termination of services. If you are booked in a standing appointment slot and you are finding it difficult to consistently keep those standing appointments, please let us know. We reserve the right to remove those standing appointments from the schedule to free up those appointment slots, and we are happy to schedule appointments one at a time for you.

I hereby give consent to Cornerstone Health Counseling to administer appropriate treatment. I also consent to the release of information for insurance purposes from my insurance company to Cornerstone Health Counseling. This signed consent shall remain in effect until it is revoked by the client or guardian, at which time written notice must be given to withdraw existing consent. I am responsible for all charges generated for services rendered including services not covered by my insurance company.

Signature of Client or Authorized Representative

Date

Printed Name of Client

(907) 522-7080

2121 Abbott Rd, Anchorage, AK 99507

cornerstonehealthalaska.org

C a r e f o r t h e w h o l e p e r s o n



Client Demographic Sheet (Adult)

General Information (Client)

First Name: _____ M.I.: _____ Last Name: _____ DOB: _____ Age: _____

Gender: _____ Social Security Number: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email address: _____

Employed: No Full time Part time Self Student Occupation: _____

Please let us know how we may contact you:

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about us? _____

Insurance Information: I do not wish for my insurance to be billed. I do not have insurance.

PRIMARY: _____ ID # _____ Group # _____

Policy Holder Name: _____ DOB: _____

Relationship to Client: Self Spouse Parent Other: _____

SECONDARY: _____ ID # _____ Group # _____

Policy Holder Name: _____ DOB: _____

Relationship to Client: Self Spouse Parent Other: _____

TERTIARY: _____ ID # _____ Group # _____

Policy Holder Name: _____ DOB: _____

Relationship to Client: Self Spouse Parent Other: _____

Signature of Client or Authorized Representative

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Care for the whole person



Adult Intake Questionnaire

Rate the items with which you are currently having problems.
 Circle the number that best indicates the existence of severity of the problem.

0 = None 1 = Minor 2 = Moderate 3 = Significant 4 = Serious

Circle the word(s) in brackets that best define(s) each statement.

Anxiety [Worry] [Fear] [Panic] [Phobia]	0	1	2	3	4
Feelings of [Depression] [Sadness]	0	1	2	3	4
Thoughts of [Death] [Suicide]	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Mood Swings	0	1	2	3	4
Grief over [Death of loved one] [Major loss]	0	1	2	3	4
Issues related to [Pregnancy] [Abortion]	0	1	2	3	4
Abuse [Physical] [Domestic] [Emotional] [Ritual]	0	1	2	3	4
Sexual Abuse [Incest] [Rape]	0	1	2	3	4
Parent(s) had [Alcohol] [Drug] Problem(s)	0	1	2	3	4
Marriage Problems	0	1	2	3	4
Relationship Problems with Children	0	1	2	3	4
Problems with [Parents] [Family]	0	1	2	3	4
Problems [Work] [School] [Legal]	0	1	2	3	4
Sexual {Concerns} [Problems]	0	1	2	3	4
Problem [Alcohol] [Drugs] [Smoking] [Other]	0	1	2	3	4
Feelings of [Hopelessness] [Helplessness] [Despair]	0	1	2	3	4
Memory [Forgetfulness] [Changes]	0	1	2	3	4

- Have you ever felt people were watching you? Yes No
- Do you ever hear voices? Yes No
- Do faces ever seem distorted? Yes No
- Do colors ever seem too bright or too dull? Yes No
- Have you ever attempted suicide? Yes No
- In your own words, state the concerns that bring you to counseling:



Financial Policy Agreement for Payment for Services

Any insurance co-payments are due at the time of service. At your initial appointment you must provide your insurance card and identification.

Co-Pay: A pre-set amount that is your responsibility at each visit. This is a flat rate that is subject to change each time your policy is renewed.

Co-Insurance: A percentage of your visit which will be calculated on the amount your insurance discount allows for the type of service you are receiving. This amount may change from visit to visit depending on the complexity of your appointment and or additional services rendered during your appointment.

Statements: Each month you will receive a statement for your portion of any bill that is due within 30 days of receipt. You will be asked at your next appointment for any outstanding balance payment in full unless prior arrangements for payments have been made.

Outstanding Balances: **If your responsibility balance becomes greater than \$250.00 at any time, Cornerstone Health Counseling requires payment agreements be made and followed in order to continue treatment. If at any time it is determined that good faith payments are not being made on any account. Cornerstone Health Counseling reserves the right to deny services until accounts are paid in full. Not fulfilling financial obligations to Cornerstone Health Counseling is also grounds for discharge from the practice.** If there is a credit balance on your account at any time and you are still receiving treatment, please note that the credit will be applied to future fees incurred. Overpayments on accounts will be refunded if no longer receiving services within a period of six months.

While Cornerstone Health Counseling staff strives to make sure all your financial obligation for services are clearly explained to you prior to your visit, **it is your responsibility to understand what your insurance covers and does not.** Cornerstone Health Counseling recommends you contact your insurance company by calling the number listed on your insurance card and inquire about your mental health benefits allowing you to be aware of any costs that may become your responsibility as part of your treatment with Cornerstone Health Counseling.

I also understand and acknowledge that I am personally responsible for paying Cornerstone Health Counseling for services that my health insurer will not cover due to non-payment of my health insurance premiums.

Printed Name of Client

Date

Signature of Client or Authorized Representative

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Care for the whole person



Acknowledgement of the Notice of Privacy Practices

The signature below acknowledges receipt of the Cornerstone Health Counseling Notice of Privacy Practices only.

Signature of Client or Authorized Representative

Date

Printed Name of Client



Client Election for Self-Pay for Services

- No insurance I do not wish for my insurance to be billed. I will be billing my insurance.

If you will not be billing insurance, please Initial below and sign at the bottom.

I, _____ the undersigned patient, acknowledge that I understand and agree that:

_____ Cornerstone Health Counseling may be a participating provider with _____
Name of Insurance

_____ The health plan under which I am covered may or may not include benefits for some or all the services provided by Cornerstone Health Counseling.

_____ Despite the above, I do not wish Cornerstone Health Counseling to submit a claim to my insurance for services provided to me by Cornerstone Health Counseling.

_____ Until such time as I may otherwise advise Cornerstone Health Counseling in writing, I elect to pay for all services I receive from Cornerstone Health Counseling.

_____ By election to self-pay for services, any payments I make to Cornerstone Health Counseling will not be credited toward satisfying any deductible I may be subject to under my health insurance plan.

_____ I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about this form. Any questions I may have had about this form have been answered to my satisfaction.

_____ I have freely chosen to self-pay for services after having asked Cornerstone Health Counseling about payment options and having carefully considered those options.

Signature of Client or Authorized Representative

Date

Printed Name of Client



Informed Consent for Services by Student Interns

I understand that Cornerstone Health Counseling undergraduate and advanced graduate students from the mental health profession are not yet licensed in Alaska.

I understand that all students are supervised by a minimum of a Master's prepared Clinical Supervisor. Supervision includes face-to-face supervision sessions reviewing and co-signing treatment plans, progress notes, and signing off on all other documents that go into your clinical record.

I understand that I have the right to know the name of the Student Intern, their supervisor and how to contact her or him, the front office will provide this information upon request.

Your signature below indicates that:

1. You have read the information in this document and consent to services provided by Cornerstone Health Counseling Student Interns.
2. Your protected health information (PHI) is strictly confidential and is protected by Federal and State regulations (42CFR Part 2, 45 CFR 160, 162, and 7 AAC 71.215)

Printed Name of Client

Date

Signature of Client or Authorized Representative



Extended Confidentiality

It has come to our attention that there may be individuals who you (our client) may allow to make or cancel an appointment for you.

Ethics surrounding confidentiality state that without your permission, we can neither verify nor deny you are a client of Cornerstone Health Counseling. This standard holds true even if you are seen as part of a couple; we would not give your parent/spouse/partner/friend any information regarding your treatment at Cornerstone Health Counseling, nor allow them to make, verify, or cancel an appointment without your permission.

I give the following individuals access to (please initial all that apply):

- _____ **Billing Information**
- _____ **Client Records**
- _____ **Appointment Information**

_____	Client Name	_____	Date
_____	Name	_____	Relationship
_____	Name	_____	Relationship
_____	Name	_____	Relationship

This authorization will stay in effect until you inform Cornerstone Health Counseling otherwise.



Consent for Telehealth Services

Telehealth or Telemental health is the practice of delivering clinical health care services to counseling clients using interactive video and/or audio communications.

The same laws that apply in face-to-face counseling also apply in telemental health. In other words, everything in the telemental health session remains confidential unless:

- The client/counselor learns of child, elder, or handicapped persons abuse.
- In the case of threatened homicide or suicide.
- Ordered by a judge or court to release records.

Telehealth services are provided for the convenience of our clients. Telehealth service is not required and is only used upon mutual agreement between provider and client. Telehealth services are subject to the following:

1. Telehealth services are not the same as an in-person visit, as you will not be in the same room as your provider. If your provider determines that telehealth is not adequate for a particular issue, the provider may choose to terminate and request an in-person session.
2. You have the right to withdraw consent at any time without affecting your right to future care or services.
3. Cornerstone Health Counseling will utilize technology that is HIPAA compliant as far as it is able. As the client, you have the responsibility to secure a confidential setting for yourself.
4. You understand that there may be risks, benefits and consequences associated with telemental health: disruption of transmission by technology failures, interruption, breaches of confidentiality by unauthorized persons and/or limited ability to respond to emergencies.
5. There will be no recording of any of the online sessions by either party. Written records will not be disclosed to anyone without written authorization unless required by law.
6. Services will be billed through our billing company like face-to-face visits. If for some reason your insurance company will not pay for telemental health services, you will be responsible for your bill. Before you are scheduled for a telemental health visit, please make these arrangements with our front desk at (907) 522-7080.
7. You understand that your therapist may need to contact your emergency contact and/or appropriate authorities in case of an emergency.



Consent for Telehealth Services

Emergency Protocols

Your counselor needs to know your location in case of an emergency. You agree to inform us of where you are at the beginning of each session. We also need to know who we may contact on your behalf in case of a life-threatening emergency only.

Address of My Location During Sessions:

_____ City: _____ State: _____ Zip: _____

Emergency Contact Person

Name: _____ Phone Number: _____

Address: _____

Relationship to Client: _____

I have read the information provided above and will discuss it with my therapist. I understand that the information contained in this form and my questions have been answered satisfactorily.

Signature of Client or Authorized Representative

Date