Cornerstone Brief Therapy
REGISTRATION

COMPLETE THIS INFORMATION FOR THE PATIENT: (PLEASE PRINT CLEARLY)

Name(s) _____M _____F_____

Address _____
(Do not use P.O. Box unless required)
City _____ State _____ Zip Code _____

Home Phone (____)_____Cell Phone (_____) _____

Birth Date: _____Social Security Number: _____

Education (Last Year Completed):_____

Employer: _____ Work Phone Number: _____

E-Mail Address: _____

Marital Status (Circle One) Married Single Widowed Separated Divorced

Spouses Name: _____ Birth Date: _____ SS#_____

Name and Address of Patients Physician: _____
_____

COMPLETE FOR EACH ADDITIONAL PATIENT AND IDENTIFY BY FIRST NAME:

First Name _____Date of Birth _____ Social Security # _____
Education (Last Year Completed) _____
Employer _____ Phone Number _____

First Name _____Date of Birth _____ Social Security # _____
Education (Last Year Completed) _____
Employer _____ Phone Number _____

COMPLETE IF THE PATIENT IS A MINOR:

Mother's Name _____Birth Date: _____
Social Security # _____
Father's Name _____ Birth Date: _____
Social Security # _____

How did you hear about Cornerstone? Internet Phone Book
Physician Referral (Name) _____
Referral from a friend (Name) _____
Other (Please Explain) _____
May I thank the person who referred you to me? Yes No

Signature(s) _____ Date _____

_____ Date _____

(IF THE PATIENT IS A MINOR, PARENT OR GUARDIAN MUST SIGN FOR THEM)

Signature: _____ Relationship to Patient _____Date: _____

NOTICE OF PRIVACY PRACTICES
Cornerstone Brief Therapy

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

- **Uses and Disclosures**

  Treatment: your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

  Payment: your health information may be used to seek payment from your health plan, from other sources of coverage such as EAP programs, or from credit card companies that you may use today for services.

  Health Care Operations: your health information may be used as necessary to support the day-to-day activities and management of our office.

  Law Enforcement: your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

  Other uses and disclosures require your authorization: disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization.

- **Additional Uses of Information**

  Appointment reminders: our staff will use your health information to make telephone calls to remind you of scheduled appointments.

- **Individual Rights**

  You have certain rights under the federal privacy standards. These include:

  a) The right to request restrictions on the use and disclosure of your protected health information
  b) The right to receive confidential communications concerning your medical condition or treatment
  c) The right to inspect and copy your protected health information
  d) The right to amend or submit corrections to your protected health information
  e) The right to receive an accounting of how and to whom your protected health information has been disclosed.
  f) The right to receive a printed copy of this notice.

Duties of This Office

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have reviewed and understand Cornerstone Brief Therapy's Notice of Privacy Practices.

ClientName_____

Signature_____Date_____

(If signature is not that of the client's indicate relationship to client.)_____

Health Insurance Information

Today's date:

Date of first session:

Patient's name:

DOB:

SSN:

Address:

Phone:

Insurance subscriber's name (name on insurance card):

Subscriber's SSN:

Subscriber's DOB:

Insurance Company:

Insurance subscriber's ID number:

Insurance subscriber's group number:

Insurance's customer service phone number (see back of card):

Insurance's contact name (person you spoke to):

Questions to ask when you call your insurance company:

Do I have coverage for outpatient mental health billed as an office visit?

What is the effective date of my policy?

Is pre-authorization required?

Is there a limit to the number of visits per year?

What will I pay at each visit?

Do I have a deductible? If yes, how much has been met?

Will the amount I pay at each visit change when the deductible is met?

Do I have an out of pocket max? If yes, how much has been met?

Will the amount I pay at each visit change when the out of pocket max is met?

Where should the office send my claims? (claims address)