Please use black ink

# CornerstoneVision
# Client Intake Form

## Client Information

First Name _____Middle Initial ___

Last Name _____

Address _____

City _____

State _____Zip _____

Home Phone _____

As a courtesy we can call your home (cell is not an option) for reminder calls 48 hours before your appt. Please ***initial*** whether you would like this option or not. Yes _____ No_____

Cell Phone _____

Work Phone_____

Birthdate: _____Age:_____

Social Security # _____ M/F

Occupation/Employer: _____

Marital Status: _____

Spouse's Name: _____

Physician Name _____

Email address _____

If you would like to receive our CVC newsletter

## Insurance Information

**must be completed in full if you wish to use insurance**

**Primary Insurance** _____

ID # _____

Group # _____

Auth Code _____

**Secondary Insurance** _____

ID # _____

Group # _____

Auth Code _____

## If a Minor (Must Sign Custody Addendum)

Parent(s)/ Guardian _____

Address _____

City, State, Zip _____

Home Phone _____

Work Phone _____ext _____

## Responsible for Payment

If client is an adult, this is self or other agency, such as a church assisting.
If client is a minor, parent that is responsible must sign back of this form.

Name/Agency_____

Address _____

City, State, Zip _____

Phone # _____

Contact Person_____

## OFFICE USE ONLY

| | PRIMARY | | SECONDARY | |
|---|---|---|---|---|
| Supervision | Yes | No | Yes | No |
| Treatment Plan | Yes | No | Yes | No |
| Authorization | Yes | No | Yes | No |

Ins/Fee: _____

Client: _____

Deductible _____ Max Visits _____

**Secondary**

Ins/Fee: _____

Client: _____

Deductible _____ Max Visits _____

Self pay ____ Ins. (in net) ____
Reduced Fee _____ Ins. (out of net) ____
Church Assisted ____ Other ____

Therapist _____

## OFFICE USE ONLY

### Allowed Amounts

90834 $_____ 90846 $_____

90837 $_____ 90847 $_____

96101 $_____ 96102 $_____

### Testing Benefits

Covered Y/N

Authorization Needed Y/N

Authorization Requested Y/N

Client: _____ Ded: _____

Please Turn Page Over ⇨

**INITIAL “ ☐ ” ALL BOXES AFTER REVIEW:**

## CONFIDENTIALITY

☐ CVC will maintain the practice of holding all communication between the therapist/mediator and the client in strictest confidence and will not allow information to be released to anyone without written permission or according to law. Your mental health record will be handled according to the following legal requirements: 1) Therapists are required to report circumstances wherein a client states an intention to harm self or others, in cases of recent or ongoing abuse, and with court related custodial concerns; 2) Indiana law requires reporting any activity wherein a child or adolescent describes participating in circumstances involving sexually oriented activities. It is CVC’s legal responsibility as a care provider to report such to the respective division of Family and Children’s Services (welfare) and respective police department. Thus, such information cannot be considered confidential information within the counseling setting, and so it also cannot be maintained only between the client and therapist/care provider; 3) Court ordering of unlicensed therapists to do so; 4) Notice of Privacy Practices.

☐ The **USA PATRIOT ACT**, commonly known as the “Patriot Act” signed into law on October26, 2001, stands for *Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001* (Public Law Pub L 107-56). The Act increases the ability of law enforcement agencies to search telephone, email communications, medical, financial, and other records; eases restrictions on foreign intelligence gatherings within the United States. If CVC is pursued by government agencies (FBI), records must be released.

## CANCELLATIONS

☐ Making an appointment is a contract between the therapist and the client that both will be present at the appointed hour. However, we are aware that genuine emergencies do arise which preclude the keeping of the appointment. Late cancellations, however, do not allow us to fill the hour with persons who are waiting for an appointment. *Cancellations require 24 hour notice. There is a minimum $30.00 fee for late cancellations or missed appointments**.

☐ *Note: *Missed appointments without cancellation notice will be expected to be paid at the full-fee rate and cannot be billed to insurance.* Reminder calls are a courtesy to you and do not absolve you of responsibility if by some error you do not receive your reminder. It is ultimately your responsibility to keep track of the appointments that you schedule. CVC reserves the right to exercise the option of discontinuing treatment after the second occurrence and assessing a full-fee charge against missed appointments.

## FEES

☐ I understand and agree that I am personally and fully responsible to pay for all services rendered; I am to pay in full at the time of appointment. I agree to pay any deductible or copayments required by my insurance company. I also agree to pay for any services not covered by my insurance carriers contract with CVC, *such as time my therapist spends on the phone with me or on written reports that I have requested* and other related services. Please make checks payable to Vision Counseling PC.

☐ If you feel your rights or privacy have been violated in any way you can contact the Department of Health and Human Services at 303-844-2024. Some of our therapists may participate in the following health maintenance organization: United Behavioral Health (1-00-468-2111) on behalf of the United HealthCare of Kentucky, Ltd. and United Healthcare of Ohio, Inc. If you have coverage through this HMO and have a complaint or grievance, you may call the HMO at its toll free number listed below. The HMO is required by law to try to resolve your complaint or grievance. You may also register a complaint with the Indiana Department of insurance at 1-800-622-4461. The HMO cannot retaliate against you or your provider for making a complaint.

☐ A minimum of one working day notice is required to release copies of any record for medical, billing or legal purposes (see Notice of Privacy & Practices). CVC reserves the right to bill for these services, as is customary.

☐ I understand that treatment strategies are based upon my therapist/provider being sensitive to me on all levels, including physical health, family/cultural background and spirituality, and I consent to such integration for my care.

☐ I HAVE RECEIVED, READ, AND UNDERSTAND THE ABOVE POLICIES & PROCEDURES AND THE *NOTICE OF PRIVACY PRACTICES* AND CONSENT TO TREATMENT.

Signed:_____ Date_____
Client/Guardian/Custodial Parent

Witnessed:_____ Date_____
Must be 18 or older