From the practice of _____,

an Affiliate of **Cornerstone Behavioral Healthcare**

Client#

Consolidated Demographic: Identifying Information

If this case is being *REOPENED,* please check this box. ☐

Service Type: ☐**Substance Abuse** ☐**Therapy** ☐**Med** ☐**TCM** ☐**CIS** ☐**BHHO** ☐**DT** ☐**Neuro Testing**

DEMOGRAPHICS

Client Name			**Date of Birth**
Address	**City**	**State**	**Zip code**
Home Phone	**Work Phone**		**Okay to call at work?** ☐Yes ☐No
Client's Gender	**Marital Status (if applicable)**		
Guardian Name or Emergency Contact*	**Relationship to Client**	**Guardian/Emergency Contact Address and phone**	

Are you currently receiving either mental health or substance abuse services from another provider?

☐Yes ☐No If yes, provider name:

Client is appropriate for services and is set to see _____ **on:** _____
Provider Name **Date**

Is client a Consent Decree Class Member? ☐Yes ☐No	**Joint Custody*?** ☐Yes ☐No Name:
Primary Care Provider/Company Name	

MAINECARE

Mainecare Number:	Categorical ☐ Non-categorical ☐
	If applicable: Pregnant ☐ Native American ☐

PRIMARY INSURANCE CARRIER

Are you billing through CORNERSTONE BEHAVIORAL HEALTHCARE for private insurance? ( ) **Y** **( ) N**

Insurance Provider	**Guarantor**	
Guarantor Employer	**Guarantor SS#**	
Policy Number	**Group #**	
Insurance Provider Address		**Guarantor D.O.B.**
City	**State / Zip**	**Telephone #**
Copay	**Referral Needed? ( )** Y ( ) N	**Referral #**

SECOND INSURANCE CARRIER

Insurance Provider	**Guarantor**	
Guarantor Employer	**Guarantor SS#**	
Policy Number	**Group #**	
Insurance Provider Address		**Guarantor D.O.B.**
City	**State/Zip**	**Telephone #**
Copay	**Referral Needed? ( )** Y ( ) N	**Referral #**
Policy Number	**Group #**	
Insurance Provider Address		**Guarantor D.O.B.**
City	**State/Zip**	**Telephone #**
Copay	**Referral Needed?** ☐ Y ☐ N	**Referral #**

***If necessary, has any legal paperwork regarding client custody, Guardian Ad Litem, probation, or other legal documentation been provided? Yes ☐ No ☐**

Billing Policies

a. BHHO is only a MaineCare funded service. Case Management is a MaineCare funded reimbursable service, unless other sources of support are identified and approved. We require a copy of your MaineCare card to remain in your client file.

b. Your signature on this form will allow Cornerstone to bill for services and process claims. Cornerstone needs to release information such as: dates of service, length of service, diagnosis and other information as requested by our contract to receive payment.

c. If changes occur to your insurance, it is your responsibility to let Cornerstone know of these changes and to do whatever is necessary of you to restore your insurance benefits should they end and you are responsible for unpaid services. Case Managers, if made aware of your need, may help you to pursue available insurance benefits to maintain them or to have them be restored.

Consent to Use of Health Care Information

I understand that Cornerstone Behavioral Healthcare will make use of my health care information for purposes of treatment and other lawful functions of Cornerstone Behavioral Healthcare's practice, including securing payment and other usual health care operations. I understand that this information may be available to persons working on Cornerstone Behavioral Healthcare's behalf, who will be subject to the same duty of confidentiality as Cornerstone Behavioral Healthcare with respect to any of my information.

I understand that if Cornerstone Behavioral Healthcare holds certain sensitive information related to my health care, such as:

- Records covered by federal rules governing confidentiality of alcohol and drug abuse treatment programs (FDA 42 CFR 2.31)
- Records covered by state rules governing mental health services
- Records concerning my, or my child's, diagnosis or treatment for HIV or AIDS

then my specific authorization will be required to disclose such information to others. However, I consent to the use of such information by Cornerstone Behavioral Healthcare for purposes of my evaluation and treatment, and other lawful functions of Cornerstone Behavioral Healthcare's practice, including securing payment and other usual health care operations. I understand that such information may be made available to persons working on Cornerstone Behavioral Healthcare's behalf, who will be subject to the same duty of confidentiality as Cornerstone Behavioral Healthcare with respect to such information. I understand that I may refuse to allow the sharing of some or all such information, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

Attendance Policy

We value your participation as a client of Cornerstone Behavioral Healthcare. You are very important to us and we want to help you in every way we can. In order to do that, we expect you to attend your appointments regularly. When you are unable to attend your appointment you lose the benefit of what you may have learned that session and we lose the funding that allows us to keep our doors open and serve you with mental health and substance abuse programs. We realize that it can be difficult to remember appointment times, that's why we make it a point to remind you by phone the day before. We need your help with our services too. ***Please call us 24 hours in advance of your appointment if you need to cancel at our general office.***

If you must call to cancel your appointment with less than a 24 hour notice, please be prepared to explain why you were unable to cancel earlier. You may be asked if you wish to continue to receive services here. No more than 3 late cancellations within a 60 day period will be allowed.

If you choose not to call to cancel and simply no-show, your services are in jeopardy of being discontinued. We will allow no more than 2 no-shows within a 60 day period.

Most people receiving services here enjoy standing appointments, that is, the same day and the same time for each appointment. If you call with late cancellations or if you decide to no-show for a scheduled appointment, you may be placed

on a CALL FOR APPOINTMENT list. This means that in order for you to be seen by your clinician you will need to phone the office to ask if your clinician has an open appointment for that day. If they do, you may choose to be seen that day. If there are no open appointments that day you will need to call another day to see if there is an opening.

An additional fee of $45 will be required of clients that have no-showed more than 1 appointment. Payment will be expected at the beginning your next appointment unless a different arrangement has been made with the office. (MaineCare clients are exempt from the above fee)

I understand and agree to the guidelines put forth above in the Cornerstone Behavioral Healthcare Attendance Policy.

STATE OF MAINE RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

Who are Adults/Children in Need of Treatment

The following is a summary of your rights as a recipient of outpatient (nonresidential) services under the Rights of Recipient of Mental Health Services booklet from the Maine Department of Health & Human Services, 40 State House Station, Augusta, Maine 04333 (287-4200 or TTY 287-2000). If you are deaf or do not understand English, an interpreter will be made available to assist you in understanding your rights. Please also review your federal rights under the Health Insurance Portability and Accountability Act (HIPAA) summarized in Cornerstone Behavioral Healthcare's **Notice of Privacy Practices**. This notice is displayed in our waiting rooms, and you may also request a copy of same.

1. **Basic Rights**. You have the same civil, human and legal rights, which all citizens are entitled. You have the right to be treated with courtesy, respect and dignity.

2. **Right to Confidentiality and Access to Records**. You have the right to have your records kept confidential, to be released only with your informed and signed consent. (Specific circumstances where the agency can release or share your protected health information as described in the Rights book.) You have the right to review you record at any reasonable time and to add written comments to clarify information you believe is inaccurate or incomplete.

3. **Right to an Individualized Treatment Service Plan**. You have the right to a written service plan, developed by you and your worker, based on your needs and goals. The plan must: be based on your actual needs, identify how a need will be met if the service is not available; include tasks to be completed and by whom; time frames for accomplishment of tasks and goals; and criteria to determine success. If you do not agree with the plan, you have the right to request and receive a second opinion. You have a right to a copy of the plan

.

4. **Right to Informed Consent**. No service or treatment can be provided to you against your will. You have the right to be informed of possible risks and anticipated benefits of all services and treatment. You may designate a representative who is authorized to help you understand and exercise your rights, help you make decisions, or to make decisions for you. The guardian also has the right to be fully informed.

5. **Right to File a Grievance and Appeal**. You have the right, without retribution, to grieve any violation of your rights or a questionable practice. You have the right to a written response, including reasons for the decision. You may appeal any decision to the Department of Health & Human Services. For assistance contact : Office of Advocacy, 60 State House Station, Augusta, Maine 04333 (287-2205) or Disability Rights Center, P.O. Box 2007, Augusta, Maine 04330 (1-800-452-1948).

Disclosure Notice

I acknowledge that I have received a copy of Cornerstone Behavioral Healthcare's "Notice of Privacy Practices", and I have been given an opportunity to review this notice. I understand that it is Cornerstone Behavioral Healthcare's policy to treat all health care information and records as confidential, and not to disclose them unless authorized to do so. I understand that I have the right to control the disclosure of my health care information, subject to certain disclosures that are permitted or required by law, and that my health care information will not be disclosed unless:

- I have specifically authorized the disclosure
- The disclosure is permitted or required by law

I understand that it is Cornerstone Behavioral Healthcare's policy not to share any health care information with family or household members, except as specifically directed by the client or parent/guardian.

The family of household members, if any, with whom I direct Cornerstone to share my health care information, are the following (if not applicable, please note N/A):
The information that Cornerstone may share with those persons listed above, consists of (if not applicable, please note N/A): :
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO CORNERSTONE BEHAVIORAL HEALTHCARE FOR SERVICES IF IT IS SELF-PAY OR NOT COVERED BY MY INSURANCE, UNLESS I AM ALSO COVERED UNDER MAINECARE. I ALSO UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR MISSED APPOINTMENTS IF I HAVE NOT NOTIFIED CORNERSTONE BEHAVIORAL 24 HOURS IN ADVANCE. I HEREBY AUTHORIZE CORNERSTONE BEHAVIORAL HEALTHCARE TO FURNISH INFORMATION REGARDING MY DIAGNOSIS AND TREATMENT TO THE ABOVE INSURANCE CARRIERS AND/OR MAINECARE, UNLESS I AM SELF-PAY. I HEREBY AUTHORIZE PERMISSION FOR TREATMENT BY PROVIDERS OF CORNERSTONE BEHAVIORAL HEALTHCARE. **THIS SIGNATURE ACKNOWLEDGES THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE BILLING POLICY, CONSENT, ATTENDANCE POLICY, RIGHTS OF RECIPIENTS, AND DISCLOSURE NOTICE AT CORNERSTONE BEHAVIORAL HEALTHCARE. THIS SIGNATURE ALSO ACKNOWLEDGES THE PERMISSION TO TRANSPORT IF APPLICABLE AS WELL AS RELEASING CORNERSTONE BEHAVIORAL HEALTHCARE FROM LIABILITY IN CASE OF AN ACCIDENT DURING ACTIVITIES RELATED TO CORNERSTONE BEHAVIORAL HEALTHCARE, AS LONG AS NORMAL SAFETY PROCEDURES HAVE BEEN TAKEN.**

Signatures: If client is a minor, and service is Substance Abuse they must sign.	
Client (14 yrs. & older):	Date:
Authorized Rep:	Date:
Relationship to Client:	
Witness:	Date:
• **I have been offered a copy of any and all of this paperwork.**	**☐Yes ☐No**
• **In the event that my insurances change I give my permission for Cornerstone to retro-bill new insurances.**	**☐Yes ☐No**

Right to Revoke (Disclosure Notice Only)

I understand that I may revoke this authorization at any time by giving written notice of revocation to Cornerstone Behavioral Healthcare; however, this will not affect information released prior to receiving my statement. I understand that revoking this authorization may be the basis for denial of health benefits or other insurance coverage benefits.

My signature below officially revokes this authorization.	
Client:	Date:
Authorized Rep:	Date:
Relationship to Client:	
Witness:	Date: