Annual HIPAA - Signature Page

Client Name:	Client #:

Any Changes to Opening Documentation? ☐ No ☐ Yes, see below:	
Client Name:	Client Address:
Contact Number:	Guardian:
Email Address:	
The family or household members, if any, with whom I direct Cornerstone Behavioral Healthcare to share my health care information, are the following: (If not applicable, please note N/A)	
The information that Cornerstone Behavioral Healthcare may share with those persons 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 Service is Substance Abuse child must sign.

Client(14 years & older):		Date:
Authorized Rep:	Relationship to Client:	Date:
Witness:		Date:

I have been offered a copy of any and all of this paperwork. ☐ 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.

Client(14 years & older):		Date Revoked:
Authorized Rep:	Relationship to Client:	Date Revoked:
Witness:		Date Revoked: