CORNERSTONE COUNSELING

360 N. Caswell Rd, Rd. #303 Charlotte, NC

704.981.CORN fax 704.228.0005

www.CornerstoneCounselingNC.com

Financial Agreement

Services may be covered in full or in part by your health insurance or employee benefit plan. Please verify your coverage carefully by contacting your insurance provider prior to your first appointment. Your insurance company can explain your benefits, including any copay, deductible or limits on sessions. By signing this form, clients agree to allow Cornerstone Counseling of Charlotte, PLLC to release information to their insurance provider for processing claims. Clients are responsible to pay any portion of fees not covered by their insurance carrier.

Payment

Clients are responsible for all copays and coinsurances, in addition to fees for missed appointments. Clients with a balance due must make arrangements with their therapist at Cornerstone Counseling in order to schedule their next session. A credit card will be held on file for payments. The card number is encrypted and held by a secure payment program called Ivy Pay. By signing this form, I agree that this card on file will be charged for the agreed upon fee for service unless alternate payment is arranged. Clients have the option of making payment in another form, but a credit card on file is still required. Payments accepted include cash, check made out to Cornerstone Counseling, and credit cards.

Clients are responsible for missed appointments and must give a one working day, 24 hours notice of cancellation. Otherwise, clients are responsible for and will be charged the full amount of the session fee, not just the copay.

Out of Network Payments

If we are not in network with your insurance provider, as a courtesy, we will file with your insurance company for each session. You are responsible for the full fee for services. All insurance reimbursement payments will be made directly to you.

Fee for Service

Some clients may choose to not use insurance benefits to cover or offset the expense of therapy. You can request a statement or “superbill” if you prefer to file on your own at a later time. Fees:

(90791) Initial Intake Assessment $140
(90837) Psychotherapy, 60 minutes $120

Your signature on this document indicates you understand and agree with the financial policies as outlined here.

Client Name_____ Signature _____

Date:_____ Witness:_____ ☐ Card on file

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Consent for Treatment & Limits of Liability

Limits of Services and Assumption of Risks:
Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:
What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (ie. The elderly, disabled/incompetent), the therapist must report this information to the appropriate agency and/or legal authorities.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request services to the clients. The type of information that may be requested includes: types of service dates/times of service, notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Client Name_____ **Signature** _____

Date _____**Witness**_____