CORNERSTONE THERAPIES

Pediatric Behavioral, Occupational, Physical, Speech, Educational Therapy, and Evaluations
18700 Beach Boulevard, Suite 120
Huntington Beach, CA 92648
Phone: (714) 962-6760
Fax: (714) 962-5961
Email: info@cornerstonetherapies.net
Website: http://www.cornerstonetherapies.net

PATIENT INFORMATION FORM

Patient Name:		Birthdate:
Language:	Sex:	Age:
Parents Name(s):		
Address:		
City	State	Zip Code
Primary phone number:		Secondary phone:
Email:		
Referring Doctor (Required):		Phone Number:

RESPONSIBLE PARTY INFORMATION

Responsible Party Name:	
Relationship to Patient: ☐ Self ☐ Parent ☐ Other	
Birthdate:	
Address:	
Home Phone:	Cell Phone:
Work Phone:	Email:

EMPLOYER INFORMATION (RESPONSIBLE PARTY)

Employer Name:		Occupation:
Address:		
City	State	Zip Code
Phone Number:		

IN CASE OF EMERGENCY CONTACT:

Name:		Relation to Patient:
Address:		
City	State	Zip Code
Phone Number:		Work Number:

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PRIMARY INSURANCE:

Primary Insured Name:	DOB:
Insurance Name:	
ID Number:	Group Number
Do you have a secondary insurance? ☐ Yes ☐ No	

SECONDARY INSURANCE:

Primary Insured Name:	DOB:
Insurance Name:	
ID Number:	Group Number
Phone Number:	

CALOPTIMA:

Please note that patients with CalOptima are required to provide information of their coverage with their ID prior to the onset of therapy. There are a limited number of CalOptima spots available for OT, PT, & SP services; therefore, we cannot guarantee a spot will be available if changes to your insurance occur or if you fail to provide information of CalOptima coverage.

Does the patient have CalOptima? ☐ Yes ☐ No	
Effective Date:	ID Number:

Assignment and Release: I authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process the claim. I understand if my account should become delinquent, I will be responsible for all reasonable collection costs and attorney fees.

I hereby declare that the information provided is true and correct. I also understand that any willful dishonesty may render additional financial responsibilities. I understand that it is my responsibility to inform Cornerstone Therapies of all changes to the information listed above, including a change or addition of any insurance information.

We have a 24-hour cancellation policy. Any no shows or missed appointments will be charged a $35.00 fee (per session, OT/PT/SP each). ABA sessions will have a $50 no show/missed appointment fee.

Written Name: _____Signature: _____

Date: _____

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CORNERSTONE'S PROGRAM

Client Services Agreement with Parents and Cornerstone Therapies:

Welcome to Cornerstone Therapies! Thank you for choosing our team to join your child and family on this journey of growth and development. The following is a summary of Cornerstone's policies. Please read each policy fully and sign to indicate that you have read and mutually agree upon these policies. If you are unsure about a policy or require clarification, please ask the front office prior to the onset of services. When you sign this document, it will represent an agreement between you and Cornerstone Therapies to provide therapeutic services. You, as the consumer, reserve the right to withdraw at any time from these services.

The following policies are mutually agreed upon between Cornerstone Therapies and the parents/guardians of the patient to be receiving services. Please initial each policy and sign below to indicate agreement.

PARENT PARTICIPATION

Parent involvement and participation are critical components of our therapeutic services. It not only allows parents to observe and learn from therapy sessions but also ensures consistency and generalization of your child's skills. Parental /caregiver attendance is required at all visits in the home. If you come in clinic, parent participation is only required for the parent education meetings. The parent's level of participation may be analyzed and reported to the insurance company in the progress reports. At Cornerstone we believe that parents are a crucial component to the success of each child.

_____(initial) I have read, understand, and agree with Cornerstone's Parent Participation Policy

CANCELLATION POLICY

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all our clients and out of consideration for our therapists' time, we have the following appointment policies:

- 24-hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment/make-up. The family/guardians agree to notify Cornerstone Therapies before the scheduled appointment if they need to cancel. To cancel an appointment you may call the front office and leave a voicemail if our office staff is unavailable.

- If you are unable to give us 24 hours advance notice you will be charged a late cancellation fee: $35.00 (OT, PT, SP) and $50 (ABA, Group). This amount must be paid prior to your next scheduled appointment. You may reschedule your child's appointment with the front office and the late cancellation fee will be waived.

_____(initial) I have read, understand, and agree with Cornerstone's Cancellation Policy

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NO SHOW/LATE CANCELLATION POLICY

Clients who either forget or consciously choose to forgo their appointment for whatever reason will be considered a "no-show". They will be charged for their “missed” appointment which is due prior to their next appointment. Clients who do not provide 24 hours advance notice to cancel an appointment will be considered a late cancellation and will be charged the late cancellation fee. **To avoid being charged a late cancellation fee, you can reschedule your appointment with the front office. If a client misses the makeup appointment, the late cancellation fee will be reapplied to your account.** Clients that no show or late cancel three consecutive appointments or excessively no show or late cancel their weekly appointments, will forfeit their appointment time, and will need to call the office to schedule future appointments.

_____(initial) I have read, understand, and agree with Cornerstone’s No show Policy

LATE ARRIVAL/PICKUP POLICY

Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate other children, whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment provided, you will be responsible for the "full" session. Out of respect and consideration to your therapist and other patients please plan accordingly and be on time (for appointment and pick up). We ask that parents pick up their child 5-10 minutes prior to the end of the appointment to discuss progress and to allow transitional time prior to the next client.

Cornerstone Therapies requires our staff to wait 15 minutes outside of a client’s home or daycare, while calling inside the home one time before cancelling a session due to an no show of the family. If the family does not open the door or answer the phone the therapist will assume that the family is not home. Those hours will be forfeited by the family and not guaranteed to be made up.

_____(initial) I have read, understand, and agree with Cornerstone’s Late Arrival/Pickup Policy

ILLNESS POLICY

At Cornerstone we have a number of individuals we serve who are considered high-risk or medically fragile. We ask that all of our parents be courteous and refrain from bringing in a child to therapy who is showing any signs of illness (includes in-home services). If your child is exhibiting any of the following symptoms, we ask to reschedule your appointment until your child is symptom free for **24-hours:**

Fever, stomach flu (vomiting or diarrhea), pink eye (and has not been on antibiotics for 24 hours), evidence of a contagious rash or condition (e.g., chickenpox, hand foot and mouth, MRSA), cold (runny nose, green discharge, excessive coughing, or sneezing, lice or nits, and sore throat.

If a therapist in the clinic or in your home determines that your child is contagious or too ill to continue with therapy, Cornerstone Therapies will cancel the remainder of the session in home and the parent/guardian will be notified. Cornerstone Therapies’ employee may exercise the right to cancel

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your child's appointment if someone else in the household is exhibiting any of these symptoms and could expose the said employee. Any child who has had a contagious infection (e.g., hand-foot-and-mouth disease) will need clearance with a doctor's note prior to returning to therapy.

_____(initial) I have read, understand, and agree with Cornerstone's Illness Policy

MAKEUP POLICY

At Cornerstone we will always do our best to schedule makeups for any of your missed appointments. If your regular therapist is out due to illness or vacation, our front office staff will send out a substitute therapist at your regularly scheduled appointment time. If there are no available subs, the front office will contact you to provide you with alternative choices for makeup sessions. Cornerstone Therapies does not guarantee that they can fill the exact time and date or all of the hours but will make every attempt to do so. Cornerstone Therapies will make every effort to schedule make up hours that are cancelled by Cornerstone Therapies' staff within the calendar week. Regional Center does not allow make-ups after Saturday of the same week. Cornerstone Therapies reserves the right to schedule make-ups with substitute staff.

- *Vacations:* Cornerstone Therapies realizes that family vacations are important for family bonding and rest. When you know you are going to be out of town ahead of time, please let the office know so they will be able to use those slots for make ups for other clients. We will hold a time slot for two weeks, however if your family is gone for an extended time (greater than two weeks) your regular therapist may be re-assigned and you may have a new therapist upon your return from vacation. Cornerstone Therapies requests that you give as much advance notice when you are going on vacation.

- *Holiday Closures:* Cornerstone Therapies observes the following holidays and will not be providing any services during these days: New Years Day, Presidents Day, Memorial Day, July 4th, Labor Day, Veterans Day, Thanksgiving and the day afterwards, December 24, 25, and 26th. In addition, there may be additional days that Regional Center may not allow services. There may be staff development days that services will be modified. Cornerstone Therapies will inform you at least 15 days prior to closures.

_____(initial) I have read, understand, and agree with Cornerstone's Makeup Policy

_____(initial) I understand that if my therapist is out, the front office may schedule a substitute therapist to cover my child's session

SCHEDULING AND ACCOMODATIONS

At Cornerstone, we understand that scheduling and managing your child's therapy times can be difficult. We will do our best to assist you with your scheduling needs.

- *Weekly Calendar:* Cornerstone Therapies will supply your family with a weekly calendar outlining what services are rendered and parent education meetings when they start therapy.

- *Schedules:* Cornerstone Therapies will try to accommodate the child's and families' needs as much as we possibly can. Sometimes specific times are not available because another child might be in a desired spot. To ensure consistent care, we will provide you with options for times to keep a smaller

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behavior team, however, if your child has limited availability this may result in having multiple therapists across multiple days.

- *Schedule Changes:* Parents can call the front office to discuss options if there is a schedule change required for the week (e.g., time shift, location change). If there is an ongoing schedule change, we ask that you provide our front office with **at least 1-months' notice**. If you request a schedule change, the same therapists may not be available, and you may be assigned with a new therapist. After a schedule request has been made, Cornerstone will notify you whether or not we are able to accommodate those schedule changes and when those changes will take effect. Cornerstone Therapies reserves the right to be able to say no to excessive schedule change requests. Parents must submit the request for schedule change directly to the front office staff or supervisor on the case.

- *Assignment of Therapist and Supervisor:* The family/guardian understands that Cornerstone Therapies uses professional judgment when assigning appropriate therapists, parent educators, and supervisors to each case. Cornerstone Therapies reserves the right to change therapists and supervisors periodically due to scheduling or problematic circumstances. If the parent/guardian requests a change in therapists, Cornerstone Therapies will individually assess the request and reasons for the request before making any changes.

_____(initial) I have read, understand, and agree with Cornerstone's Scheduling Policy

THERAPEUTIC ENVIRONMENT/PROFESSIONAL RELATIONSHIPS

- *Materials and Supplies*: Cornerstone Therapies will provide the basic materials and toys needed to perform our job. These toys and materials are the property of Cornerstone Therapies and are solely for the purpose of therapeutic intervention. If any materials are left by the therapist, Cornerstone Therapies requests that they be given to the therapist on the next session. Cornerstone Therapies may ask the family to purchase some materials or supplies that may be helpful for the family to use in the home environment with the child's program. If a child brings a personal device to the therapy session (e.g., iPad), Cornerstone Therapies is not financially responsible if the device is lost, damaged, or broken.

- *Working Environment:* It is the responsibility of the client's family to provide a safe and comfortable working environment. Cornerstone Therapies will terminate services if a therapist is made to feel uncomfortable, unwelcome, or unsafe at any time in the environment. Any kind of harassment of Cornerstone employees is not allowed. Cornerstone Therapies reserves the right to terminate in-home sessions if a client's home is unsanitary (e.g., dirty diapers left on the floor, urine or feces, lice, excessive smoke, pests, drugs, etc.) and not conducive to providing services. The family/guardian understands that it is inappropriate for members of the family to discuss personal issues with the therapist if they are not relevant to intervention, and your child's programming.

- *Parent/Guardian Presence:* The Client/family/guardian understands and agrees that, pursuant to the laws of the State of California, Cornerstone Therapies, and its employees ***are not permitted to remain in the home alone with any minor, child, or dependent for the purpose of rendering services unless such minor, child or dependent is accompanied by a parent or assigned caretakers present in the home at all times throughout the session.*** The client/family/guardian agrees that if he/she leaves or in otherwise not able to be present for any reason whatsoever at any time prior to the completion of such session, Cornerstone Therapies shall immediately terminate such session and

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promptly leave the premises. Finally, the Client/family/guardian understands and agrees that they shall not request or otherwise seek to have Cornerstone Therapies' employees take any responsibility whatsoever for the temporary custody of the child. The Client/family/guardian agrees that "Assigned caretakers" must be a minimum of 18 years of age. Cornerstone Therapies' employees are not allowed to remain inside the home if an assigned caretaker is a minor.

- *Shadowing:* Cornerstone Therapies may periodically send a staff member with your regularly assigned therapist in home or in center to observe a session. This is a very critical and integral part of our training process which enables new staff to be exposed to a variety of programs and children which are at different stages of development. Occasionally, Cornerstone Therapies directors, or coordinators may choose to observe a portion of a session or a staff member's performance without giving prior notice and may arrive at your home unannounced.

- *Professional/Dual relationships:* Employees and families are prohibited to engage in any dual relationship. Therapists and BCBA's have ethical guidelines that they must uphold as part of their certifications. One component is to make sure their relationship with their clients is professional at all times. Therapists and BCBA's are not allowed to become "friends" on any social media. Therapists cannot have a social relationship with a family nor participate in personal events such as birthday parties. All email communication should be through Cornerstone Therapies, not through personal emails. Parents should only contact Cornerstone staff during work hours. If it is a nonurgent matter, please email the parent educator to discuss any issues. Texting or calling Cornerstone staff should only occur in the case of immediate schedule or location changes.

- *Solicitation of Cornerstone Therapy Employees:* The family/guardian understands and agrees that Cornerstone Therapies staff may not work for the client on a private basis under any circumstances. Cornerstone Therapies will terminate services immediately with the client if the client attempts to solicit any Cornerstone Therapies employee for private work during or outside of normal business hours. Cornerstone Therapies has a "do not compete "policy that employees sign that they will not work with any client that has been a Cornerstone Therapies client for a minimum of 2 years after termination of services. This includes if the child leaves Cornerstone Therapies or if the employee leaves Cornerstone Therapies. The family/guardian understands that supplementation of a Cornerstone Therapies employee's salary by the family/guardian is forbidden by this agreement.

_____(initial) I have read, understand, and agree with Cornerstone's Therapeutic Environment/Professional Relations Policy

PROGRAM ADHERENCE

- *Intervention:* Cornerstone Therapies is providing your child with direct intervention. Direct intervention is defined as delivery of the program and face-to-face contact with the client and members of his/her family. Services are provided based on your child's current level of individualized needs. The treatment plan will structure antecedent and consequence-based strategies that are skill based and non-aversive. Data collection is a very integral part of direct intervention. We use this data to analyze progress and plan future interventions. Cornerstone Therapies' employees will be taking data via direct observation throughout the session and will spend time at the end of the session to make sure all data is recorded, and percentages calculated. Therapists may spend the first several minutes of session setting up materials and will begin to transition clients 5-10 minutes prior to the end of the appointment time to

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allow opportunities to discuss your child's progress. Progress reports are typically written every 6 months and submitted to the insurance company.

- *Therapist Supervision:* Cornerstone Therapies provides initial training as well as ongoing training for employees to ensure quality interventions are taking place. This requires staff members to attend staff meeting as well as periodic education workshops and conferences. Your child's program may have a supervisor assigned to his/her case and a supervisor will be reviewing data and monitoring your child's progress frequently. A supervisor may come out to your home to watch a therapist's delivery of intervention and be taking data at the same time to record inter observer agreement. This is to ensure treatment integrity and consistency of behavior analytic techniques across staff.

- *Prompting:* To assist your child with learning, different tasks may require a level of physical prompts in which your therapist will guide the learner's hands or physically guide your child. Your therapist has been trained to always utilize the least restrictive interventions, and physical prompts should never be used for compliance unless there is a safety concern. Please let your therapist know if you are not comfortable with this type of prompt strategy.

- *Compliance with treatment recommendations:* If you as the guardian, do not agree with treatment recommendations provided by your therapists you have the right to discuss it with your team. It is important for the family to carry out these techniques and recommendations throughout the week even when the Interventionist is not in the home for maximal improvement. If the family refuses to comply with these recommendations your child's progress could be negatively affected. Parents must understand that the risk of non-compliance with treatment may affect your child's progress and could possibly lead to termination of services. Cornerstone Therapies reserves the right to reconsider the appropriateness of services when there in noncompliance with the program.

- *Alternative treatments:* Please be aware that alternative treatments could affect your child's response to therapy. Thus, it is important to make the supervisor/therapist aware of those other interventions and to partner with the team to evaluate any associated therapeutic or detrimental effects of those interventions.

- *Discharge/Discontinuation of services:* I understand that every 6 months-1 year insurance companies may requires Cornerstone Therapies to reassess levels and progress towards goals for my child. Each insurance has its own guidelines and I understand that my child might progress so that they no longer are approved for the same level of service. This may result in a decrease in hours or transition to a "less restrictive environment' such as a group setting. I understand I have the right to withdraw at any time from these services and I understand that such a withdrawal will not affect my child's right to access other early intervention services. If I wish to withdraw for any reason, I agree to discuss it with my supervisor and contact Cornerstone Therapies.

_____(initial) I have read, understand, and agree with Cornerstone's Program Adherence Policy

HIPAA, PATIENT CONFIDENTIALITY, & PRIVACY PROTECTION

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not

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use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

- *Confidentiality, Duty Not to Discuss or Disclose Certain Information:* Cornerstone Therapies acknowledges that during the term of this agreement, it may have access to and become familiar with confidential information regarding the client, or the client's family. Cornerstone Therapies agrees that it will not discuss or disclose any information of a confidential nature or use any such information with a third party except as required by law unless it obtains written consent of the client.

- *Videotaping Recording by Cornerstone Therapies:* Cornerstone Therapies may occasionally video tape your child during intervention to track your child's progress more effectively. The purpose of the video is to enable Cornerstone Therapies staff to review your child's program, progress, and staff performance. These video tapes are strictly confidential. They will not be shared with anyone without your permission. These tapes are not available to the client or third parties. The client/parent/guardian will be asked to complete a Video Release form outlining the guidelines and permissions prior to any videoing. Clients may watch such videotapes with their supervisor upon request.

- *Videotaping Recording by Client or Third Party:* At Cornerstone we have an open-door policy and encourage parents in home to be present during sessions. Due to our strict HIPAA policies, videotaping or photography is not allowed of the session. This is to protect the privacy of our clients. If you wish to take video for training/learning purposes, please discuss options available with your therapist/case supervisor.

_____(initial) I have read, understand, and agree with Cornerstone's HIPAA/Privacy Policies

MANDATED REPORTING

- *Mandated reporting:* Cornerstone Therapies employees are considered mandated reporters under penal code (pc 11165.7) in the state of California. The family/guardian understands that Cornerstone Therapies' employees are **required** to and shall immediately report and /or notify any governmental agency of any and all indications of child abuse and/or neglect observed or there is reasonable suspicion of abuse or neglect detected before, during, or after the course of any session. Cornerstone Employees are also mandated reporters for missing children in the State of California.

_____(initial) I have read, understand, and agree with Cornerstone's Mandated Reporting Policy

CORNERSTONE GRIEVANCE POLICY

Our goal at Cornerstone Therapies is to meet the child's needs as determined by parents and professionals as a team. We would like to know if you are not happy with any part of your child's program. If you have a complaint, we ask that you please call or speak with one of the department managers: Coral Ly and Katherine Davis (ABA), Heather Spowart (SP), Rachel Ridings (OT), and Sandra Head (PT). You may also request to speak with the directors of Cornerstone Therapies: Katherine Davis and Rachel Ridings. If your concerns cannot be resolved, you may request a copy of your therapist's or supervisor's credentials at any time or file a formal complaint to the governing body.

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All complaints will be documented and if necessary written goals or objectives will be provided to the parent as possible solutions to the complaint. If all measures are taken and you are still not happy with the solutions, you have the right to request another facility or program at any time.

_____ (initial) I have received, read, understand, and agree with this Cornerstone's Grievance Policy

LANGUAGE ASSISTANCE PROGRAMS POLICY

1. Cornerstone Therapies has provided to your insurance company (or payor of services) what languages are spoken in our facility.
2. If you do not speak English and wish to have an interpreter for your assessment in your native language, please let us know before your assessment so that we can contact your insurance company to provide an interpreter for you.
3. We discourage minors to translate for you.
4. We have trained our staff on your insurance company's policy on language assistance program requirements.

_____ (initial) I have received, read, understand, and agree with Cornerstone's Language Assistance Programs Policy

CONSENT TO TREAT MINOR

_____(initial) I grant Cornerstone Therapies the authority to obtain medical treatment for the following child(ren)_____, _____.

The above providers are authorized to provide: Infant Stimulation, ABA therapy, Occupational Therapy, Physical Therapy, and Speech Therapy Treatment/evaluations. This temporary authority shall begin on:_____(date) and remain effective until terminated by understanding.

I have read and understand the above statements and consent to treatment with Cornerstone Therapies.

Parent's Name: _____ Signature: _____ Date:_____

Therapist Name: _____ Signature: _____ Date:_____

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INSURANCE AND BILLING INFORMATION

Understanding benefits and insurance requirements can be difficult and at Cornerstone we will try and assist you with this process. Every insurance company and individual plans have different benefits, and we ask that prior to services, our parents take time to understand their coverage and what that means for their child's therapy services.

PATIENT RESPONSIBILITY

As healthcare providers, and as a courtesy to our patients we are willing to call and obtain an explanation of your benefits as it relates to the services obtained through our facility. We are given information from your insurance company, but please be advised that the benefits quoted it is not a guarantee of payment. Since you are ultimately responsible for knowing your benefits and your cost responsibilities, it highly recommended that you also check with your insurance company regarding your cost share for the services you are pursuing. Your insurance is a contract between you, your employer, and the insurance company. We are willing to bill the insurance on your behalf, but we are obligated to charge the copayments, coinsurance, and deductibles that are associated with your plan and indicated on your explanations of benefits. Most insurance companies have an online service where families can check services billed and payments rendered. We recommend that families continue to check their insurance claims to ensure your insurance company is continuing to pay for benefits. Any services not paid by insurance will be the financial responsibility of the patient; patients that are not covered for services through their medical insurance, can opt to pay on a cash basis.

CONTRACTS

Prior to beginning therapy services, we may be required to obtain certain documentation depending on your insurance company's requirements. Prior to therapy, our front office and billing department will call to verify your benefits including your coverage and patient responsibility. Depending on your insurance, you may be required to have a diagnosis with diagnostic testing by a qualified professional (as outlined by your insurance company) and/or an accompanying prescription for services. Each insurance company and plan will have different benefit options for their members. It is best to check with your individual plan prior to the start of services. In the event that your insurance changes, you would need to let both the front office and your therapist know immediately to check

COVERAGE ACKNOWLEDGEMENT NOTICE

_____(initial) Due to the possible changes of insurance benefits and coverage, I realize that I am responsible to notify Cornerstone Therapies/NW/CF INC of any insurance changes or if my coverage is terminated, as these changes can affect my child's treatment.

PAYMENT AGREEMENT AND ASSIGNMENT POLICY

_____ (initial) I agree to be responsible for my copays, deductibles, coinsurance, and other charges not covered by my insurance, except when prohibited by agreement between my Insurance company and Cornerstone Therapies. I acknowledge the fact that Copays, Deductibles, and Coinsurance are due at the time

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of service. I understand that a $35.00 fee per 1-hour session will be implemented for any no show, missed appointments, or late cancellations (less than 24-hour notice) for OT/PT/SP. ABA sessions have a $50 fee.

_____ (initial) I have read, understand, and agree with the cancellation policy.

ARBITRATION CLAUSE

Any controversy or claim arising out of this agreement or any alleged breach of this agreement shall be resolved by means of binding arbitration. The arbitrator's award shall be final, and the judgment may be entered upon by any court having jurisdiction thereof. You would be responsible for your attorney fees.
_____(initial) I agree to this policy.

VERIFICATION OF BENEFITS POLICY

As a courtesy, our billing department will call or go online to obtain your benefits as they pertain to the services for which we will bill. Occasionally what we are initially given may be different from what we receive on the explanation of benefits (EOB) after we bill. As a preferred provider we are obligated to charge the amount on the EOB. It is the subscriber's (guardian's) responsibility to obtain and understand their benefits. This can be accomplished by going online, talking with your human resources representative, or reading your policy. As the subscriber you are responsible for your deductible, copays, or coinsurance, and are in agreement with your insurance company to pay for these fees when you receive these services. All payments are due at the time of the service, and if you have another individual dropping off your child for therapy, you must arrange for them to bring the payment. If you have a maximum number of visits allowed per year, as the subscriber you are responsible to keep track of them, to not exceed this maximum benefit. If you do exceed this maximum benefit you will be responsible for the entire cost of the therapy sessions. Since you may be receiving other services from other clinics, you must keep track of the combined services visits, to not incur additional costs. We will attempt to let you know if we are seeing a problem with your insurance company rendering payment in a timely manner, so that you can also call them to verify that they will be paying for the rendered service. We would be happy to answer your questions and assist you in interpreting the explanation of services that you receive.

_____(initial) I agree with this policy.

CORNERSTONE THERAPIES

Pediatric Behavioral, Occupational, Physical, Speech, Educational Therapy, and Evaluations
18700 Beach Boulevard, Suite 120
Huntington Beach, CA 92648
Phone: (714) 962-6760
Fax: (714) 962-5961
Email: info@cornerstonetherapies.net
Website: http://www.cornerstonetherapies.net

Notice of Receipt
Cornerstone Therapies/Charlotte Feichtmann Physical Therapy/
Nina Welch Speech Pathology
Notice of Privacy Practices
Notice Date Effective September 23, 2013

____ I hereby certify that I have received a copy of the September 23, 2013 Notice of Privacy Practices for the above-referenced providers.

Parent's Name: _____ Signature: _____ Date:_____

____ I hereby certify that I have been offered a copy of the September 23, 2013 Notice of Privacy Practices for the above-referenced providers, and I declined to accept the notice.

Parent's Name: _____ Signature: _____ Date:_____

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RELEASE OF INFORMATION

I, _____ (name) hereby consent to Cornerstone Therapies, giving and/or receiving information pertaining to my child _____ (client name) with the persons or agencies listed below. A photocopy of this document shall be considered to be as valid as the original. This release shall be in effect until revoked.

Parent's Name: _____ Signature: _____ Date:_____

Person/Doctor	Address/Phone/Fax
_____	_____
_____	_____
_____	_____
_____	_____

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EMERGENCY MEDICAL CONSENT

Re: _____ DOB: _____

To Whom It May Concern:

I, the undersigned, give parental consent for my child to receive emergency medical attention if needed. I give my consent for my child to be admitted to and discharged from any hospital, as well as to provide diagnosis and treatment, given under the supervision of any physician, surgeon, or dentist which is licensed under the Medical Practice Act or the Dental Practice Act.

Parent's Name: _____ Signature: _____ Date:_____

Witness: _____

Physical Accommodations/Medical Information

Are there any physical limitations, medical issues (seizures, allergies), or modifications your child may need within a session? Please list:

_____

_____

Does your child have any allergies (please circle): Yes No

Please list all known allergies (**If none please put N/A**):

_____

Primary Physician: _____

Address & Phone: _____

Medical Disabilities: _____

Infectious/contagious condition: _____

Special Nutritional needs: _____

In case of an emergency please list two emergency contacts:

Name:_____Relation:_____Phone Number:_____

Name:_____Relation:_____Phone Number:_____

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PHOTO/VIDEO CONSENT
(sign on both the top and bottom sections)

I, _____ hereby give consent to Cornerstone Therapies to take a photograph or video of my child _____. These may or may not be used for educational purposes or published on our website. A photocopy of this document shall be considered to be as valid as the original. This release shall be in effect until revoked.

Signed: _____ Date: _____

-or-

I **DO NOT** give consent to publish photos or video on the website.

Signed: _____ Date: _____

I, _____ hereby give consent to **parents** of Cornerstone Therapies clients to take a photograph or video of my child _____ during holidays, birthday parties, etc. These photos will be for private use only. A photocopy of this document shall be considered to be as valid as the original. This release shall remain in effect until revoked.

Signed: _____ Date: _____

-or-

I **DO NOT** give consent for my child, _____, to be photographed or videotaped by parents.

Signed: _____ Date: _____

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RECEIPT OF PACKET

By signing this form, I confirm that I have read Cornerstone's policies and understand that not adhering to these policies may result in the termination of services. I understand that if I have any questions about these policies, I may reach out to the case supervisor or front office.

Child's Name: _____

Parent/Legal Guardian Name: _____

Signature: _____

Date: _____