



PATIENT INFORMATION FORM

GENERAL INFORMATION

Patient Name:		DOB:	
Primary Language:		Sex:	Age:
Parents/Caregivers Name(s):			
Address:			
City:		State:	Zip Code:
Primary phone number:		Secondary phone:	
Please indicate whether the front office can contact you through text messages regarding scheduling: ☐ Yes ☐ No			
Email:			
Referring Doctor (Required):		Phone Number:	

PATIENT HISTORY

Birth History/Developmental History (Premature birth, did they achieve developmental milestones, was there any regression in skills?):
Medical History (Please provide existing diagnosis, health concerns, allergies, or hospitalizations):
Reason for Referral (Please state your concerns or therapeutic needs):
Previous/Current Services:



History of Custody or Existing Custody Issues (Please provide if there are any specific custody arrangements that our staff should be aware of):

Daily Routines/Schedule (School, sports, classes):

Child Strengths and Interests (Please list preferred activities or strengths that your child has):

Family Concerns (Please check a box if you have concerns in any of the following areas):

- ☐ Communication
- ☐ Daily Routines
- ☐ Social/Play
- ☐ Behavior/Emotional Regulation
- ☐ Sensory Processing
- ☐ Feeding Motor/Function Safety

Are there any challenging behaviors or safety issues that the staff should be aware of for session? (Please list):

RESPONSIBLE PARTY INFORMATION

Responsible Party Name:		DOB:	
Relationship to Patient:			
Address:			
City:	State:		Zipcode:
Home Phone:		Cell Phone:	
Work Phone:		Email:	

EMPLOYER INFORMATION (RESPONSIBLE PARTY)

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

EMERGENCY CONTACT

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

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/MEDICAL

Please note that patients with CalOptima/Medi-Cal are required to provide information of their coverage with their ID prior to the onset of therapy. All CalOptima/Medi-Cal clients are required to disclose their membership and the failure to disclose coverage may be considered insurance fraud. Per CalOptima/Medi-Cal member guidelines, CalOptima/Medi-Cal clients must pursue services through a vendor that is contracted and cannot seek or attempt to pay for services directly with an unauthorized vendor. Cornerstone Therapies is currently contracted for CalOptima/Medi-Cal primary through ABA services only.

____ (initial) I have read the above statement and understand that I am required to provide accurate information regarding my CalOptima/Medi-Cal Coverage and that a failure to disclose can be considered insurance fraud.

Does the patient have CalOptima/Medi-Cal? ☐ Yes ☐ No	
Effective Date:	ID Number:

ATTESTATION OF INSURANCE COVERAGE

____(initial): I understand that it is my responsibility to notify the front office immediately of any changes to my insurance coverage and that changes in coverage may result in a loss of services through Cornerstone Therapies.

____(initial): I authorize payment of benefits to 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.

____(initial): I hereby declare that the information provided is true and correct. I also understand that any willful dishonesty may render additional financial responsibilities and can be considered insurance fraud.

Written Name: _____ Signature: _____ Date: _____



CLIENT SERVICE AGREEMENT

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 to the clinic, parent participation is only required for the parent education meetings but is encouraged if parents would like to observe sessions and discuss progress. The parent's level of participation may be analyzed and reported to the insurance company in the progress reports.

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

CANCELLATION/NO-SHOW 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. We ask that clients do not contact the therapists directly to cancel their appointments and instead contact the front office for day-to-day scheduling changes.
- If you are unable to give us 24-hour advance notice you will be charged a late cancellation fee of \$100. The first late cancellation of the year will be waived, but all subsequent late cancellations will incur a late cancellation charge. This amount must be paid prior to your next scheduled appointment and if not paid your future appointments may be placed on hold. To avoid being charged a late cancellation fee, you also have the option to reschedule your appointment with the front office by the end of the week. If a client misses the makeup appointment, the late cancellation fee will be charged to your account..
- Clients that excessively late cancel or no-show to their weekly appointments may forfeit their weekly appointment times. Any client that no-shows or late cancels three sessions may forfeit their appointment time and will need to contact the front office for any future appointments. Clients with excessive absenteeism may also forfeit their ongoing appointment spots and Cornerstone Therapies cannot guarantee availability with the same therapist or therapy time.

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



LATE ARRIVAL/PICK-UP

Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate other clients whose appointments follow yours. Depending upon how late you arrive, your therapist may then determine if there is adequate time to begin treatment. 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 prior to cancelling an appointment. If you are nonresponsive, the therapists will mark the appointment as a no-show/late cancellation and will return to the clinic.

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

ILLNESS POLICY

At Cornerstone Therapies we have a number of individuals we serve who are considered high-risk or medically fragile. We ask that all 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, sore throat, and/or other signs of illness).

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, and the parent/guardian will be notified. Cornerstone Therapies' employees may exercise the right to cancel 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 SESSIONS/SUBSTITUTE THERAPISTS

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. Additionally, our staff may have scheduled conferences, school meetings (IEPs), or continuing education trainings that conflict with your session 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 but will attempt to make up all missed hours of your appointment.

- **Substitute Therapists:** At Cornerstone Therapies we encourage families to work with substitute therapists to assist your child with generalization of their skills and to allow another practitioner to provide suggestions or different approaches to your child's therapy. Substitute therapists can facilitate a collaborative approach in which your child will benefit from all of our practitioner's specialties and knowledge. If you are not comfortable with substitute therapists, please notify the front office at the start of your services.
- **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.

____(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. If I am not comfortable with a substitute therapist, I should notify the front office prior to the start of services.

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 it is already held by another client. To ensure consistent care, we will provide you with options for times to keep a smaller therapeutic 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 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 at the next session. 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 may terminate services if a therapist is made to feel uncomfortable, unwelcome, or unsafe at any time. 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 is 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 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 from engaging 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 contracted to provide your child with direct intervention utilizing evidence-based practice. 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 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 meetings 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 attend your child's session 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 therapeutic 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 therapist and family to have consistent techniques in which they are addressing the client's goals. If the family and therapy team cannot determine a feasible alternative therapy approach or the parents/guardians are not participating, this may lead to a termination of services. Cornerstone Therapies reserves the right to reconsider the appropriateness of services when there is limited follow through 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 require 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 are no longer 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

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 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 to be present during sessions. Due to our strict HIPAA policies, videotaping or photography is not allowed during the session with the therapist present. 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

THERAPEUTIC ENVIRONMENT/PROFESSIONAL RELATIONSHIPS

- **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: Jorge Ruiz-Aguilar (ABA), Heather Lewis (SP), Rachel Ridings (OT), and Sandra Head (PT). If your complaint cannot be resolved with the department managers, 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.

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 POLICY

1. Cornerstone Therapies has provided 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 primary language, please let us know prior to your appointment so that we can contact your insurance company/funding source to provide an interpreter for you.
3. We discourage minors from translating 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 POLICY

_____(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:_____



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 are not a guarantee of payment. Since you are ultimately responsible for knowing your benefits and your cost responsibilities, it is 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 your benefits.

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 of service. I understand that a \$100.00 fee will be implemented for any no show, missed appointments, or late cancellations (less than 24-hour notice).

_____ (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 with 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.

By signing below, I am acknowledging that I have read the above policies regarding patient responsibility and billing practices for Cornerstone Therapies. I understand that any payments that are considered patient responsibility are due at the time of service and that non-payment may result in the cancellation or rescheduling of my child's appointment.

Written Name: _____ **Signature:** _____ **Date:** _____



CREDIT/DEBIT CARD ON FILE & PAYMENT AUTHORIZATION

Patient Name: _____

Parent/Legal Guardian: _____

Date of Birth: _____

CARD ON FILE REQUIREMENT

Cornerstone Therapies requires patients/families who may have financial responsibility for services to maintain a valid credit or debit card on file, except where prohibited by law, payer requirements, contractual requirements, or other applicable regulations.

Card information is maintained securely through our payment processing system. Cornerstone Therapies does not maintain the complete card number in the patient's clinical record.

AUTHORIZATION TO CHARGE CARD

I authorize Cornerstone Therapies to charge the credit or debit card I have placed on file for amounts that are my responsibility, as permitted by applicable law and payer requirements.

These charges may include:

- Copayments;
- Coinsurance;
- Deductibles;
- Private-pay or self-pay services;
- Non-covered services for which I have agreed to be financially responsible;
- Approved cancellation or missed-appointment fees in accordance with Cornerstone Therapies' cancellation policy; and
- Other patient-responsibility balances that I have been notified are due.

Cornerstone Therapies will not charge my card for amounts that are the responsibility of my insurance company, Regional Center, or another third-party payer.

INSURANCE CLAIMS AND PATIENT RESPONSIBILITY

When applicable, Cornerstone Therapies will submit claims to the patient's insurance plan or other responsible payer according to the terms of the patient's coverage and Cornerstone Therapies' payer agreements. The amount ultimately owed by the patient/family may not be known until the claim has been processed.

I understand that I remain responsible for applicable copayments, coinsurance, deductibles, and other patient-responsibility amounts as determined by my health plan and permitted under applicable law and payer agreements.



I understand that verification of insurance benefits is not a guarantee of payment by my insurance company.

NOTICE OF CHARGES

When feasible, Cornerstone Therapies will notify me of patient-responsibility balances before charging the card on file, particularly when the amount differs substantially from routine copayments or other expected charges.

A receipt or other record of payment will be provided or made available following a charge.

I may contact Cornerstone Therapies if I believe a charge is incorrect or have questions regarding my account.

CANCELLATIONS AND MISSED APPOINTMENT FEES

If Cornerstone Therapies maintains a cancellation or missed-appointment policy, I understand that applicable fees may be charged to my card on file when permitted by law and applicable payer requirements.

I understand that cancellation or missed-appointment fees are separate from charges submitted to insurance or other third-party payers unless otherwise permitted.

REGIONAL CENTER/EARLY START AND OTHER FUNDED SERVICES

Families receiving services funded by a Regional Center, Early Start, or another government or third-party program will not be charged for services or amounts for which the family does not have financial responsibility.

A card on file will not be charged for Regional Center-authorized services when those services are the financial responsibility of the Regional Center.

If a family separately elects to receive private-pay services or other services for which the family has agreed to be financially responsible, those charges may be processed according to this authorization.

DECLINED OR EXPIRED CARDS

I agree to maintain a valid payment method on file while receiving services when this policy applies to me.

If the card on file expires, is declined, or otherwise becomes unavailable, Cornerstone Therapies may request an updated payment method.

Outstanding balances remain the responsibility of the patient/parent or legal guardian to the extent permitted by law and applicable payer requirements.

DISPUTED CHARGES AND OTHER BILLING QUESTIONS

If I have a question or concern regarding a charge, I agree to contact Cornerstone Therapies so that the practice has an opportunity to review the account and correct any billing error.



Nothing in this agreement limits any rights I may have under applicable federal or California law or my cardholder agreement.

REFUNDS AND ACCOUNT ADJUSTMENTS

If Cornerstone Therapies determines that an overpayment has occurred, the account will be adjusted and any refund due will be processed in accordance with Cornerstone Therapies' refund procedures and applicable law.

AUTHORIZATION

By signing below, I acknowledge that:

1. I have read and understand this Credit/Debit Card on File & Payment Authorization.
2. I authorize Cornerstone Therapies to maintain my payment method securely through its payment processing system.
3. I authorize Cornerstone Therapies to charge the payment method for patient-responsibility amounts described in this agreement.
4. I understand that this authorization does not permit Cornerstone Therapies to charge me amounts for which I am not legally or contractually responsible.
5. I understand that I may request information regarding charges made to my account.
6. I understand that this authorization remains in effect while the patient receives services from Cornerstone Therapies unless it is revoked or replaced, subject to amounts already incurred and applicable law and payer requirements.

Patient Name: _____

Parent/Legal Guardian Name: _____

Signature: _____

Date: _____

Relationship to Patient: _____

PAYMENT METHOD

- ☐ **Credit Card**
☐ **Debit Card**
☐ **Other approved electronic payment method**

Card ending in: _____

Expiration: _____

This information is kept in a password protected document in accordance with HIPAA and PCI guidelines. Some parents elect to use this as their primary source of payment and the total amount incurred for the week is deducted



from this account. If you notice there has been an error in your electronic transfer of funds with the amount charged, you must notify us within 60 days. Call 714-962-6760 and ask for Vania or the billing department.

For security purposes, the complete card number and security code should not be recorded on this form.

FOR OFFICE USE ONLY

Payment method securely stored/tokenized: ☐ Yes

Staff Initials: _____

Date: _____

Notes/Exceptions: _____



NOTICE OF RECEIPT OF PRIVACY PRACTICES
NWSPI, CORNERSTONE THERAPIES, CFPTI

____ (initial) 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: _____

____ (initial) 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: _____



AUTHORIZATION FOR RELEASE OF INFORMATION

Release of Information • 1 of 2

1. PATIENT / CHILD INFORMATION

Patient/Child Full Name: _____ Date of Birth: _____

2. AUTHORIZED EXCHANGE OF INFORMATION

I authorize Cornerstone Therapies to:

- ☐ Release information TO the person/organization below
- ☐ Obtain information FROM the person/organization below
- ☐ Exchange information in BOTH directions

Person / Organization: _____

Contact Person / Title: _____ Relationship: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

3. INFORMATION AUTHORIZED

Check only the information that may be released/obtained:

- ☐ Evaluations / assessments
- ☐ Treatment plans / plans of care
- ☐ Progress reports / clinical notes
- ☐ Attendance / scheduling information
- ☐ Diagnosis / medical or developmental history
- ☐ Billing / insurance / authorization information
- ☐ Regional Center / IFSP information
- ☐ School / educational information
- ☐ Entire applicable record
- ☐ Other (describe specifically): _____

4. RECORD / SERVICE DATE RANGE

The authorization applies to information for the following dates of service/records:

Start Date: _____ End Date: _____ ☐ All applicable dates

5. PURPOSE OF DISCLOSURE / EXCHANGE

- ☐ Coordination of care / treatment
- ☐ School / educational coordination
- ☐ Regional Center / service coordination
- ☐ Insurance / payment
- ☐ At the request of the patient/representative



☐ Other purpose: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Release of Information • 2 of 2

6. AUTHORIZATION EFFECTIVE PERIOD

This authorization is effective for the period below. Unless a longer period is specifically requested, Cornerstone will use an expiration date no more than one year from the date signed.

Effective / Start Date: _____ Expiration / End Date: _____

OR expiration event (if applicable): _____

7. IMPORTANT AUTHORIZATION TERMS

1. I understand that I may revoke this authorization at any time by providing a written request to Cornerstone Therapies. Revocation will not affect information already used or disclosed in reliance on this authorization.
2. I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law.
3. I understand that I may refuse to sign this authorization. Except where permitted by law, Cornerstone Therapies will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
4. I understand that I have a right to receive a copy of this signed authorization and instructions for obtaining additional copies or a digital copy.
5. I authorize only the information, persons/organizations, purposes, and dates identified on this form. A copy or electronic copy of this signed authorization may be treated as valid as the original.

8. SIGNATURE / AUTHORITY

By signing below, I acknowledge that I have read and understand this authorization.

Patient/Parent/Legal Representative Name: _____

Relationship / Authority to Act for Patient: _____

Signature: _____ Date: _____

9. FOR CORNERSTONE THERAPIES USE ONLY

Date Received: _____ Verified By: _____

Date Revoked: _____

Notes: _____

Provide the signer with a copy of the completed authorization. Retain the signed authorization with the patient record.





EMERGENCY MEDICAL CONSENT

Re: _____ DOB: _____

To Whom It May Concern:

I, the undersigned, give parental consent for my child to receive emergency medical attention or first aid 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: _____



PHOTO/VIDEO CONSENT

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 videos 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. 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: _____



A LITTLE ABOUT ME

We are so excited to work with your child. Please feel free to share any information that helps us better provide your child with a positive therapeutic experience.

Activities I love:	
My favorite toy:	
My favorite color is:	
Things that make me smile:	
How I communicate:	
My favorite food:	
I don't like it when...	
Something you should really know about me...	
I learn best when...	
I love when people...	☐ Give me praise ☐ Give me High Fives ☐ Give me Hugs ☐ Give me Tickles ☐ Give me space ☐ Give me quiet time ☐ Other _____