CORNERSTONE OF HOPE BEREAVEMENT CENTERS
FEE SCALE

Cornerstone of Hope is committed to providing professional counseling services to the bereaved in a way that is cost-effective. If finances are a concern, we will work with each family accordingly. What is paramount is to serve those who grieve with excellent care and compassion.

Typical clinical counseling fees range from $125 to $150/hour or $30 co-pays with limited sessions covered by insurance plans. These plans often prohibit an individual or family's ability to access quality care and to complete the emotional work they've begun.

Payment: Expected prior to session. For alternate arrangements contact counselor*.
***Please note that your copayment is based on your total family income information that you have provided to us on this form and acknowledged by your signature. This copayment will be due at your first appointment, and every appointment thereafter, unless your financial situation changes during the time that you are receiving counseling from the Cornerstone of Hope counseling staff.

EAP – Employee Assistance Plan
(Your employer may cover a portion of the counseling cost through an EAP program, ask your Human Resource Department if this benefit is available to you/your family.)

I understand that fees must be paid at the time of service unless other arrangements are made. Please check off your total household income amount below so that we may determine your correct co-payment amount.

Rate per Individual per Session

Total Family Income	1 Person	2 Persons	3 or more	Total
□ $100,001 and above	$70	+$20	+$10	$_____
□ $80,001 - $100,000	$60	+$20	+$10	$_____
□ $70,001 - $80,000	$50	+$20	+$10	$_____
□ $60,001 - $70,000	$40	+$20	+$10	$_____
□ $50,001 - $60,000	$30	+$10	+$10	$_____
□ $40,001 - $50,000	$20	+$10	+$10	$_____
□ Below $40,000	$10	+$10	+$10	$_____

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Client Name (Please print) Counselor (Please print)

_____ _____
Parent/Guardian Name (Please Print) Date

CORNERSTONE of Hope
5905 Brecksville Road, Independence, Ohio 44131 • 216.524.4673
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Revised 11/15/16

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CORNERSTONE OF HOPE
CONSENT FOR TREATMENT

Client ID_____

NAME: _____ DATE: _____ TIME: _____ am/pm

Consent for Treatment

1. I, the undersigned, hereby give my permission to undergo any assessments, treatment or other procedure deemed reasonable and necessary by Cornerstone of Hope staff for my diagnosis, treatment, follow-up or referral at Cornerstone of Hope. This may include, but is not limited to, emergency care, psychosocial assessment, psychiatric assessment, counseling, and any other behavioral health services provided as part of my treatment. My consent shall also include a personal history, which will assist the staff in developing a treatment plan, and in providing treatment. I give my consent for individual, couple, family and or group therapy as deemed necessary by the Cornerstone of Hope Program staff. I give my consent for the staff of Cornerstone of Hope to share information with one another about my treatment.

2. I hereby acknowledge that mental health treatment is not an exact science and I further acknowledge that no guarantee or assurance has been made to me with respect to or concerning treatment to be given to me at Cornerstone of Hope.

3. I hereby authorize payment directly to Cornerstone of Hope of benefits due to me for reason of treatments and procedures afforded to me and further assign any major benefits due, all of which payment shall not exceed the regular services of the Cornerstone of Hope or the staff thereof for the treatment afforded to me. I agree that a photocopy of this authorization is as valid as the original.

4. MEDICARE PATIENTS ONLY
   I authorize any holder of medical or other information about me to release the Social Security Administration or its intermediaries or carriers, any information needed for this or any subsequent Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment of such claim.

_____ _____

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE STAFF SIGNATURE

Date: _____ Date _____

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CORNERSTONE OF HOPE
NOTICE OF PRIVACY PRACTICES

Client ID_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Our Commitment to Your Privacy
Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional services and care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. A copy of this information is available at any time by contacting us at 216-524-3787. Please contact us with any questions or problems you may have.

We will use information about your health that we get from you or others mainly to provide you with treatment, to arrange payment for services, and for other business activities that are called in the law health care operations. After you have read this Notice of Privacy Practices, we will ask you to sign a consent form. The consent form will allow our agency to use and share your information. If you do not sign this consent form, we cannot treat you.

For Treatment
We use medical information to provide you with psychological services or treatment. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of our services.

With your consent, we may share or disclose your PHI to others who provide treatment to you, or we might share your information with your personal physician. If you are being tested by a team, they can share some of your PHI with us so that services you receive will be coordinated. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment. If your PHI is transmitted via email, your information will be kept confidential by the use of encryption that meets the requirements of current regulations. Mobile apps to share PHI should not be utilized.

For Payment
We may use your information to bill you, your insurance, or others so we can be paid for the treatment or services we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we have met your progress, and similar sorts of information.

For Health Care Operations
There are a few ways we may use or disclose your PHI for what are called health care operations. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

Other Uses in Healthcare:
Appointment Reminders
We may use and disclose information to reschedule or remind you of appointments for treatment or care. If you want us to call or write to you only at home or work or prefer some way that we reach you please let us know.

Treatment Alternatives
We may use and disclose your PHI to tell you about or recommend possible treatment alternatives that may be of help to you.

Other Benefits and Services
We may use and disclose your PHI to tell you about health related benefits that may be of interest to you.

CORNERSTONE OF HOPE
NOTICE OF PRIVACY PRACTICES

Business Associates
There are some jobs that we might hire other businesses to do for us. In the law they are called our Business Associates.
Examples include a telephone answering service or a billing agency. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information, and follow all applicable laws, rules, and requests to endure security of your PHI.

Uses and Disclosures That Require Your Authorization
If we want to use your information for any purpose besides those described above, we need your permission on an authorization form. If you do authorize us to use or disclose your PHI, you can revoke or cancel that permission, in writing, at any time. After that time we will not use or disclose your information for the purposes we agreed upon. Of course, we cannot retract any information we have already disclosed with your permission.

Exceptions to Confidentiality and Privacy of Information
There are certain situations where we are unable to keep information private by law. They are as follows:

1. When there is a serious threat to your health or safety or the health or safety of another individual or the public.
2. When we are required by a court of law to disclose information
3. Some instances where a law enforcement official requires us to disclose information to maintain your safety or that of others.
4. For Worker's Compensation and similar benefit programs
5. When we receive information about abuse or neglect of a child, disabled adult, or person over age 65.

Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you; however, we do not discuss PHI informant via text or email.
2. You have a right to ask us to limit what we tell people involved in your care or the payment for your care such as family members and friends. While we do not have to honor your request, if we do honor it we will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as medical or billing records. You can even get a copy of these records, but we may charge you. Contact us at the location above to make such arrangements.
4. If you believe the information in your records is incorrect or missing important information, you can request us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to us at the location listed above. You must tell us in your request the reasons you are requesting the changes.
5. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures prior to April 14, 2003. If you make an accounting request more than once in a twelve month period, we will charge you $0.25 per page for the accounting statement.
6. You have a right to a copy of this notice. If we change this Notice of Privacy Practices, you may obtain a copy of the new notice from the address listed above.
7. If you have a problem with how your PHI has been handled or feel your privacy rights have been violated, contact the Clinical Director at 216-524-3787. You have a right to file a complaint with us and the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care or take any actions against you if you file such a complaint.

_____ _____
Parent/Guardian Signature Date

_____ _____
Client Date

_____ _____
Agency Representative Date

❑ A copy of this form has been given to me

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CORNERSTONE OF HOPE
CLIENT RIGHTS AND RESPONSIBILITIES

Client ID_____

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy;
2. The right to service in a humane, least restrictive setting which is the least restrictive feasible as defined in the treatment plan;
3. The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives;
4. The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal;
5. The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral;
6. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan;
7. The right to be free from intellectual, emotional and/or physical abuse;
8. The right to be free from abuse, financial or other exploitation, retaliation, humiliation, and neglect;
9. The right to access to information pertinent to the client in sufficient time to facilitate his/her decision making;
10. The right to informed consent, refusal or expression of choice regarding service delivery, release of information, concurrent services, composition of service delivery team, and involvement in research projects, if applicable;
11. The right to access or referral to legal entities for appropriate representation, self-help support services, and advocacy services;
12. The right to freedom from unnecessary or excessive medication;
13. The right to freedom from unnecessary restraint or seclusion.
14. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written in the client's current service plan;
15. The right to be informed of and refuse any hazardous treatment procedures;
16. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies, or photographs;
17. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense;
18. The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court-appointed guardian of the person of an adult client;
19. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client and other persons authorized by the client the factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information that the client has made accessible. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records;

CORNERSTONE OF HOPE
CLIENT RIGHTS AND RESPONSIBILITIES

20. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event;
21. The right to receive an explanation of the reasons for denial of service;
22. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay;
23. The right to know the cost of services;
24. The right to be fully informed of all rights;
25. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service;
26. The right to file a grievance;
27. The right to have oral and written instructions for filing a grievance, and
28. The right to investigation and resolution of alleged infringement of rights.
29. The right to not have your photo used in any form of social media, including COH's Facebook page, without your written consent.
30. Other rights as may be defined by state or federal authorities.

Your Responsibilities

- Actively participate in your treatment and help to develop your plan of care with a Cornerstone of Hope staff member.
- Take part in planning and participating in your own psychosocial treatment program and provide information concerning your mental health and medical history.
- Ask a question(s) when you do not understand what is happening to you.
- Let a member of the staff know when you have a problem or feel sick.
- Show respect for the property and rights of others.
- Obey the laws which apply to all citizens.
- Be familiar with and observe the rules and policies of Cornerstone of Hope.
- Accept responsibility for your actions.
- Cooperate with the goal of achieving self-sufficiency in the management of your everyday living.
- As a client of Cornerstone of Hope you have a guaranteed right to a place to come, a guaranteed right to meaningful relationships, and a guaranteed right to a place to return.
- Grievance – Perceived Violation of Client Rights: The Clinical Director shall serve as Client Rights Representatives for Cornerstone of Hope and shall function in this capacity as specified in the Client Grievance Policy.

_____ _____
Parent/Guardian Signature Date

_____ _____
Agency Representative Date

_____ _____
Client Date

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