CORNERSTONE
FAMILY
RESOURCES

6 South State Street
Concord, New Hampshire 03301-3761
(603) 228-3862 Fax (603) 226-0073

RECEIPT OF THERAPY AGREEMENT

Client's Name: Today's Date:_____

Address: _____ Date of Birth:

Responsible Party:

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS **PSYCHOTHERAPIST/ PATIENT SERVICES AGREEMENT** AND AGREE TO ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE SEEN THE HIPPA NOTICE DISPLAYED IN THE WAITING ROOM AND ARE AWARE A COPY IS AVAILABLE TO YOU UPON REQUEST.
IF THERAPY IS FOR YOUR DEPENDENT CHILD, YOU ARE AGREEING TO THESE TERMS FOR HIS/HER TREATMENT. IN FAMILY THERAPY, PARTIES HAVE EQUAL ACCESS TO THE RECORDS.

Signature of Patient or Guardian Date

Printed Name

INSURANCE BILLING AUTHORIZATION

- ❑ I authorize the release of any medical or other information required to process this claim.
- ❑ I also request payment of any benefits directly to Cornerstone Family Resources.
- ❑ I authorize the release of any billing information requested by the above-mentioned responsible party/parties.

Signed: (Client or Guardian) Date:

FOR OFFICE USE ONLY

Date of Intake : Diagnosis :

Therapist : _____ Referral Source:

PQRS Outcomes	Depression	Alcohol Use	Tobacco Use
Age			
CPT Billing Code			
Numerator			
Modifier			