Welcome to Cornerstone Psychiatric Services

Thank you for choosing Cornerstone Psychiatric Services. We are pleased to have the opportunity to provide you with excellent service rendered by caring and qualified clinicians.

Initial Visit Deposit

A **$60.00 deposit** is required to reserve your first appointment. This is due to a significant number of patients not showing up for their initial appointment, which denies other patients the opportunity to secure an appointment and receive care. You may use a credit card, cash, or personal check made payable to "**Cornerstone Psychiatric Services, Inc.**"
Please note that we cannot reserve your appointment until we receive this deposit. Options for making this deposit:

□ Initial Visit Deposit already applied to account.
We have scheduled an appointment for you on_____ at _____a.m./p.m. with the provider
□ David M. Donahue, D.O. □ David R. Fawks, APRN □ Nina R. Kirchgessner, APRN □ Joan Flynn, LCSW

-OR- select one of these options below:

□ Mail your deposit check when returning the completed New Patient Intake form and we will call you back once received to confirm your appointment details.
□ Come into our office and hand deliver your completed New Patient Intake form along with your deposit amount.
□ Complete this Credit Card Authorization section and return back to us with your completed New Patient Intake form and we will call you back once received to confirm your appointment details.

Patient Name:_____ Patient Account#:_____
I authorize Cornerstone Psychiatric Services, Inc. to charge $60.00 to my ___MasterCard® ___Visa® ___Discover®

Card Number __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Exp. Date (month/year) ____/_____ CSV:_____
(3 digit code on back)

Name as it appears on the card_____

Signature (in ink) _____ Date _____

- This deposit will be placed on your account as a credit to be used toward copays, coinsurance, deductibles, or any non-covered services; including Initial Missed Appointment Fee of $60.00.
- The deposit is fully refundable if you cancel 24-hours before your scheduled appointment time.
- If you need to reschedule your initial appointment to a later date, and you provided us the advanced 24-hour notice, this deposit will be used to secure this next appointment.
- Cancellations made with less than 24-hours notice or missing your initial appointment will forfeit the $60.00 deposit and is non-refundable, and another deposit must be made to schedule a new appointment.

Please complete the enclosed **New Patient Registration Form-Patient Intake and mail back in the return envelope provided along with your Initial Visit Deposit option (if not already paid).** Your ***completed information is essential*** for you to receive timely treatment. <u>You keep this first page, unless returning it with credit card payment toward deposit.</u>

We anticipate that you will find your involvement in treatment to be beneficial to you. In order to maximize the effectiveness of our intervention it will be important for you to demonstrate a willingness to honestly discuss your symptoms, thoughts, feelings and behaviors with your clinician. The goal of working together is to enhance your ability to deal with factors contributing to your present problems. You will find that the process in moving toward this goal can sometimes feel unsettling while at other times freeing and comforting.

<u>Follow-up Visit policy:</u> Our Services are by appointment only. All payments are due at the time of service. Because your appointment represents valuable time for both you and your clinician we request that you notify us at least ***24 hours in advance of a cancellation*** or need for change. **If you fail to give the necessary 24-hour notice a $60 fee will be assessed.** It will be your responsibility to pay this fee. If you miss or cancel less than 24-hour notice, we will use any remaining amount of your Initial Deposit towards the $60 no-show fee. Certain unforeseen events taking place prohibiting you from canceling beforehand will certainly be considered in the assessment of any fees.
Payment is due at time of service unless alternative arrangements have been made. As a courtesy, we will only require your designated co-pay or deductible (*unless otherwise indicated by your health plan*) and will bill your insurance company.

TURN PAGE for additional information, map and checklist ►

Because the quality of our service delivery relies heavily on organization and appropriate planning we request that you be prompt for your scheduled appointments. We have made available our privacy and policy forms—Patient Right and Responsibilities, Notice of Privacy Practices, Office Policies and Patient Portal Policy and Procedures on our website www.cornerstonepsychiatric.com. These forms are available by request in our office as well.

It is often difficult for our clinical staff to immediately respond to telephone calls. If your situation is urgent please notify the receptionist at the time of your call and we will do our best to facilitate a timely response. **If you are in an emergency situation, please call 911 or go directly to the nearest emergency department.**

We are privileged to be able to serve you. Thank you for choosing us as your behavioral healthcare provider.

Cornerstone Psychiatric Services, Inc.
1790 E. Venice Ave. Ste 204
Venice, FL 34292
(O) 941.488.8884 (F) 941.488.5554
www.cornerstonepsychiatric.com

Located on the corner of Auburn Rd and Venice Ave. Two story building on the corner that is next to Moose Lodge and American Legion Hall. Building entrance is on the West side of the building through the double glass doors. Take elevator or stairs to 2nd floor and we are in Suite 204.

Checklist:

√ Initial Visit Deposit of **$60.00** paid in advance of scheduling first appointment by cash, check or credit card.
√ Complete your New Patient Intake Form and returned back to our office before your appointment.
√ Reviewed Privacy and Policies available on our website, www.cornerstonepsychiatric.com or at our office.
√ Day of your appointment: Bring photo id, insurance card(s) if we are billing any, and any additional information you want to share with us.
√ Complete Authorization for Use or Disclosure of Protected Health Information form. We encourage one with your Primary Care Provider contact information so we have coordination of care. Please one provider or name per form. So, if you have additional providers/names..i.e. prior mental health provider, caregiver, etc. Please complete a separate form for each.