

# Patient Demographic

UPDATE FORM



# Cornerstone Psychiatric Services, Inc.

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1790 E Venice Ave. Ste. 204, Venice, FL 34292  
Ph: (941) 488-8884 Fax: (941) 488-5554 Medical Records Fax: (941) 375-0119

Patient Account#: \_\_\_\_\_  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Suffix:  JR  SR  III  IV or \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Gender:  Male  Female Marital Status:  Divorced  Married  Separated  Single  Widowed  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email\*: \_\_\_\_\_ Home#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
\*Your email will be used to invite you to Patient Portal access. Work#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Race:  White – Non Hispanic  Black – Non Hispanic  American Indian/Alaskan Native  
 Pacific Islander  Asian  Other: \_\_\_\_\_  
Ethnicity:  Hispanic  Non-Hispanic  Unknown Language:  English  Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Contact#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

## COMMUNICATING WITH YOU

**How do you prefer to receive appointment reminder notifications?**  
 Email  Voice Call to:  Home  Mobile  Work  Other  SMS/Text to Mobile  
You agree and acknowledge that email, calls, texts or any form of messaging to your home, mobile, work or other contact will pertain to information regarding things like appointments, patient portal, test results, medication side effects and prescriptions. If you wish to extend communication regarding your specific medical treatment and share of information with others, we ask that you sign a Release of Information form. If this information should at any time need to be modified, please complete a new Patient Demographic Form and/or ROI form with your requested change(s) If you wish to opt-out of any form of communication, please specify here \_\_\_\_\_.  
If you give permission for us to communicate with anyone else, please complete the list below:

Name and relationship	Contact #	Options
Name: _____ Relationship: _____	(____) _____ - _____ <input type="checkbox"/> Check this box if this is a cell phone number	<input type="checkbox"/> Appointment Information <input type="checkbox"/> Billing Information <b>Note: If you wish to grant medical release of information (ROI) you must complete the ROI form.</b>
Name: _____ Relationship: _____	(____) _____ - _____ <input type="checkbox"/> Check this box if this is a cell phone number	<input type="checkbox"/> Appointment Information <input type="checkbox"/> Billing Information <b>Note: If you wish to grant medical release of information (ROI) you must complete the ROI form.</b>

## PREFERRED LAB AND PHARMACY AND PRIMARY CARE PROVIDER

Please provide us your default choice of Lab company you use and which local pharmacy and mail order pharmacy you primarily use.  
**Lab:**  Quest Diagnostics  Labcorp  Millennium Phys Group Lab Svc  Bayfront Health Venice  Other: \_\_\_\_\_  
**Local Pharmacy:**  Costco  CVS  Publix  Sam's Club  Target  Walgreens  WinnDixie  Other: \_\_\_\_\_  
**Pharmacy Store#, Address or phone#:** \_\_\_\_\_  
**Mail Order Pharmacy:**  CVS Caremark  Express Scripts  OptumRx  PrimeMail  Other: \_\_\_\_\_  
**Primary Care Provider (PCP):** \_\_\_\_\_

## INSURANCE / FINANCIAL RESPONSIBILITY

**Primary Payer:**  Self pay  Aetna \_\_HMO or \_\_PPO  BeaconHealth  BCBS/FL BLUE \_\_HMO or \_\_PPO  Cigna  Magellan  
 Medicare (traditional)  Medicare Advantage: \_\_\_\_\_  Tricare  United Healthcare/UBH  Other: \_\_\_\_\_  
**Insurance ID#:** \_\_\_\_\_ **Group#** \_\_\_\_\_ **COPAY (if known):** \_\_\_\_\_  
**Secondary Payer (if any):**  Aetna  AARP by UHC  Bankers Life  BCBS  Cigna  Golden Rule  Magellan  
 Medicare 2nd  Tricare  United Healthcare/UBH  BeaconHealth Options/ValueOptions  Other: \_\_\_\_\_  
**Insurance ID#:** \_\_\_\_\_ **Group#** \_\_\_\_\_ **COPAY (if known):** \_\_\_\_\_


**INSURANCE ASSIGNMENT AND SELF PAY AGREEMENT  
AUTHORIZATION TO RELEASE**

>I certify that I have insurance coverage with the primary insurance company, if applicable; and the secondary insurance payer, if applicable, listed above. I assign directly to "Cornerstone" Psychiatric Services, Inc. (including David Donahue, D.O., David Fawks, APRN, Nina Kirchgessner, APRN, Smitha Ajesh, APRN, Joan Flynn, LCSW, Nancy Stetter-Coblentz, LCSW or any clinician with the Cornerstone group), all insurance payments, if any, otherwise payable to me for services rendered. I understand I am financially responsible for deductible, co-payments, co-insurance amounts, non-covered charges, and any and all balances not covered under a contractual agreement between "Cornerstone" and my insurance or other third party payer. I authorize the use of my signature for all insurance submissions. I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to "Cornerstone" for any services furnished to me by that provider.

>If Self Pay, I understand it is my responsibility to pay for services rendered at time of visit.

>I understand and agree that "Cornerstone" may use my health care information to the above named insurance payer(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that if an authorization is needed from my insurance plan, it is my responsibility to obtain such authorization and provide this to "Cornerstone".

**Signature of Patient, Parent or Personal Representative:**

SIGN HERE  
PLEASE! 

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Print name of Patient, Parent or Personal Representative:** \_\_\_\_\_

**Relationship of Patient:**  Self  Parent  POA/Caregiver

**CONSENT TO TREAT / CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION  
CONSENT FOR OFFICE POLICIES and PATIENT PORTAL POLICIES AND PROCEDURES**

- **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by a state licensed clinician at **Cornerstone Psychiatric Services, Inc.** This consent is knowingly and freely given. This consent will expire 7 years after my last encounter visit at **Cornerstone Psychiatric.**
- I hereby give my consent for **Cornerstone Psychiatric Services and their Business Associate's** (such as, but not limited to, medical billing company, EHR vendor, collection agency, automated appointment reminder vendor, dictation service, Prescription Drug Monitoring Program database, and electronic prescription vendor) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). You can ask for a copy of the Notice of Privacy Practices provided by **Cornerstone Psychiatric Services** which describes such uses and disclosure in detail.
- I have the right to review the Notice of Privacy Practices prior to signing this consent. **Cornerstone Psychiatric Services** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Privacy Officer at 1790 E Venice Ave. Ste 204, Venice, FL 34292.** You can also pick up a copy in our office.
- With this consent, **Cornerstone Psychiatric Services** may communicate to me in reference to any items that assist the practice in carrying out TPO, such as, but not limited to, appointment reminders, billing statements, insurance issues and any messages pertaining to my clinical care, including laboratory test results, among others by use of phone calls to my home, mobile or other alternative location and speak or leave a message; SMS/Text message, Email, postal delivery and/or by the Patient Portal.

**By signing this form, I am consenting to mental health treatment; I authorize Cornerstone Psychiatric Services to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cornerstone Psychiatric Services may decline to provide treatment to me.**

I understand and agree with all the preceding information unless otherwise indicated in writing. I have received or been offered to review a copy of the following documents: Cornerstone "Notice of Privacy Practices", "Office Policies", and "Patient Portal Policy and Procedures". I agree and accept the terms of all these documents. Copies of these documents are available at your request in our office or by downloading from our website, [www.cornerstonepsychiatric.com](http://www.cornerstonepsychiatric.com).

**Signature of Patient, Parent or Personal Representative:**

SIGN HERE  
PLEASE! 

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Print name of Patient, Parent or Personal Representative:** \_\_\_\_\_