

Patient Demographic

UPDATE FORM



Cornerstone Psychiatric Services, Inc.

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◇ Joan Flynn, LCSW

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 Note: If you wish to grant medical release of information (ROI) you must complete the ROI form.
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 Note: If you wish to grant medical release of information (ROI) you must complete the ROI form.

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, Joan Flynn, 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.

Signature of Patient, Parent or Personal Representative:

SIGN HERE
PLEASE! 

Date: ____/____/____

Print name of Patient, Parent or Personal Representative: _____