Patient Demographic
UPDATE FORM

Patient Account#:_____
Date: _____/_____/_____

Cornerstone Psychiatric Services, Inc.
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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:_____-_____-_____ **Spouse Name:**_____ **Contact#:**(_____)_____-_____

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:_____

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:	( ) _____ - _____ □ Check this box if this is a cell phone number	□ Billing Information □ Appointment Information □ Medical/Health Information □ All of the options
Name: Relationship:	( ) _____ - _____ □ Check this box if this is a cell phone number	□ Billing Information □ Appointment Information □ Medical/Health Information □ All of the options

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 □ 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 □ BeaconHealth/ValueOptions □ BCBS □ Cigna □ Golden Rule □ 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, and Gerald Horton, LCSW), 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:**_____

Print name of Patient, Parent or Personal Representative:_____

Relationship of Patient: □ Self □ Parent □ POA/Caregiver **Date:**_____

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.

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____

Print name of Patient, Parent, Guardian or Personal Representative