Patient Intake Form

Appointment Date and Time:_____

Patient Account#:_____

***Initial Visit Deposit of $60 is required** before securing your initial appointment. Refer to Welcome Letter for details.

For CPS office use: □ Initial Deposit Received

Cornerstone Psychiatric Services, Inc.

David Donahue, D.O ◊ David Fawks, APRN ◊ Kristoffer Guerrero, APRN
Smitha Ajesh, APRN ◊ Lenice Haber, LCSW ◊ Nancy Stetter-Coblentz, LCSW
1790 E Venice Ave. Ste. 204, Venice, FL 34292
Phone: (941) 488-8884 Fax: (941) 488-5554

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **Middle Name:**_____

Suffix: □ JR □ SR □ III □ IV or _____ **Preferred Name:**_____ **Date of Birth:**_____/_____/_____

SSN: _____ - _____ - _____ **Relationship Status:** □ **Divorced** for ____years □ **Married** for ____ years

Birth Gender: □ Male □ Female □ **Separated** for ____years □ **Single** for ____years □ **Widowed** for ____years

Gender Identity: □ Same as Birth Gender □ Transgender Female □ Transgender Male □ non-binary
□ Identifies as Male □ Identifies as Female □ Identifies as Gender Neutral

Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual □ Prefer not to disclose

Street Address:_____**City:**_____ **State:**_____ **Zip:**_____

Email*:_____ *Your email will be used to invite you to Patient Portal access.

Home#: (_____) _____ - _____ **Mobile#:**(_____) _____ - _____

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:**_____

PATIENT STATUS

Student Status: □ Full-time □ Part-time □ Not a student **School/College Name:**_____

Employment Status: □ Full-time □ Part-time □ Not Employed □ Disability □ Retired □ Self Employed □ Active Military duty

If working, what is your occupation:_____ □ Other:_____

Employer Name: _____ **Employer Work#:** (_____)_____-_____

Employer Address:_____ **City, State and Zip:**_____

COMMUNICATING WITH YOU

How do you prefer to receive appointment reminder notifications?

□ Email Voice Call to: □ Home □ Mobile □ Work □ Other □ SMS/Text to Mobile/Cell

You agree and acknowledge that email, calls, texts, voicemail and 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 (please check options)
Name: Relationship:	( ) _____ - _____ □ Check this box if this is a cell phone number	□ Appointment Information □ Billing Information **Note: If you wish to grant medical release of information (ROI) you must complete the ROI form.**

REFERRAL and PCP INFORMATION

If you were referred to our practice, please provide name and phone number:

Referred by:_____ Referred phone#:_____

Please provide your **Primary Care Provider** (PCP) contact info: PCP Name: _____ Phone:_____

PCP Street Address:_____ City: □ Venice or _____ St: □ FL or ____ Zip:_____

LAB CHOICES

Tell us which lab company you normally use: □ Quest Diagnostics □ Labcorp □ Bayfront Health Venice
□ Millennium Physician Group Lab Svc □ SMH Lab located at:_____ □ Other:_____

PHARMACY and PRESCRIPTION PLAN

Tell us which local pharmacy and mail order pharmacy that you use to fill your prescriptions:

Local Pharmacy:□ Costco □ CVS □ Publix □ Sam's Club □ Target □ Walgreens □ Wal-mart □ WinnDixie □ Other:_____

Local pharmacy Name, Store#, Address and phone#:_____

Mail Order Pharmacy: □ CVS Caremark □ Express Scripts □ OptumRx □ PrimeMail □ Other:_____

Prescription Plan Coverage: What company provides your prescription coverage? Check one option below:

□ Aetna Rx □ FL Blue (PrimeTherapeutics) □ Caremark □ Cigna Rx □ Express Scripts □ Humana Rx □ OptumRx □ Silverscript
□ Other (please print name):_____ □ No Rx Coverage

Rx Id#:_____ RxGroup#:_____ RxBin:_____ RxPCN:_____

INSURANCE / FINANCIAL RESPONSIBILITY

Primary Payer: □ Self pay □ Aetna HMO or □ Aetna PPO □ BCBS/FL Blue PPO or □ BCBS/FL Blue HMO □ Carelon Behav □ Cigna
□ Golden Rule □ Magellan □ Medicare (traditional) □ Tricare □ United Healthcare/Optum Behavioral □Other:_____
□ **Medicare Advantage Plans:** (□ Aetna Mdcr __HMO or __PPO □ BCBS/FL Blue Medicare__HMO or __PPO □ United Healthcare Medicare)

↑↑↑ (CHECK ONE BOX ABOVE FOR YOUR INSURANCE PAYER NAME or CHECK 'SELF PAY' BOX IF NO INSURANCE) ↑↑↑

Primary Insurance ID#:_____ **Group#**_____ **COPAY (if known):**_____

Insurance Co. Claim Mailing Address, City, State, Zip:_____
Insurance Co. Payer ID (if printed on ins. card; usually 5 digits): _____

Subscriber's Full Name: □ Same as patient □ Other name:_____

Subscriber's Birthdate:_____ **Subscriber's SS#:**_____

Secondary/Supplemental Insurance Payer: **(complete this section only if you have a secondary payer or supplement plan)**

Important Notice: We do not accept Florida Medicaid, out-of-state Medicaid plans or any Medicaid HMO plans

□ Aetna □ AARP by UHC □ Bankers Life/Colonial Penn □ BCBS/FL Blue □ Cigna □ Constitution Life □ Golden Rule □ Magellan
□ Medicare Secondary □ Mutual of Omaha □ Tricare □ United American Ins □ United Healthcare/UBH/Optum Behavioral
□ UMR □ Carelon Behavioral (formerly Beacon Health) □ Other:_____

2nd Insurance ID#:_____ **Group#**_____ **Plan:**_____ **COPAY (if known):**_____
2nd Insurance Co. Claim Mailing Address, City, State, Zip: _____

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, Smitha Ajesh, APRN, Kristoffer Guerrero, APRN, Lenice Haber, 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, missed appointment fees, 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".

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

Print name of Patient, Parent or Personal Representative:_____
Relationship of Patient: □ Self □ Parent □ POA/Caregiver **Date:**_____

PATIENT CONSENT FOR EVALUATION OR TREATMENT
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 staff from **Cornerstone Psychiatric Services, Inc.** I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
*The benefits of the proposed treatment *Alternative treatment modes and services
*Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).

The evaluation or treatment will be conducted by one or more of the following provider types: a psychotherapist, a psychologist, a psychiatric nurse practitioner (APRN/ARNP), a psychiatrist, a licensed clinical social worker, a licensed therapist or an individual supervised by any of the professionals listed. I understand that clinicians David Fawks, Kristoffer Guerrero and Smitha Ajesh are APRN's.

Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Clients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings, and sensations such as guilt, anxiety, anger, or sadness, especially in its initial phases. It is not uncommon for these feelings to have an impact on current relationships you may have. If this occurs, it is very important to address these issues in session. Usually these unpleasant sensations are short lived. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

* 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 or download a copy from our website www.cornerstonepsychiatric.com of the Notice of Privacy Practices provided by **Cornerstone Psychiatric Services** which describes such uses and disclosure in detail. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Center of Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

* 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.

* It is further understood that all information given by the patient or family member to a treating clinician is ***confidential*** and will not be released, except under special circumstances, without patient consent or consent of legal guardian as described in details in the Notice of Privacy Practices. You can authorize us to release information relating to your treatment to another person, provider or company by signing a Release of Information (ROI) form provided by our office.

By signing this form, I am consenting to allow 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 acknowledge that I have received or been offered to review a copy of the following documents: Cornerstone "Welcome Letter", "Patient Rights and Responsibilities" , "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.

X_____ _____

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

_____

Print name of Patient, Parent, Guardian or Personal Representative

HEALTH SCREENING INFORMATION

The following information is provided by: □ Patient (self) □ Parent □ Family member:_____ □ Other:_____

Birthplace (City and State): _____

Current Housing Situation: □ Living alone □ Living with spouse □ Living with partner □ Living with roommate(s)
□ Living with parents □ Living with brother/sister □ Living with aunt/uncle □ Living with grandparent
How many in household, including yourself? _____

Advanced Directives:
□ None □ Do Not Resuscitate □ Living Will □ Durable Power of Attorney (provide copy) □ Healthcare Proxy (provide copy)

1. Chief Complaint: What is the reason for your visit?

□ Addiction	□ Confusion	□ Helpless	□ Medication Effects	□ Phobia
□ ADHD	□ Depression	□ Hopeless	□ Memory problem	□ Self-injury
□ Anger/Temper	□ Energy level decreased	□ Impulsivity	□ Obsession/ OCD	□ Suicidal Thoughts
□ Anxiety	□ Grief	□ Irritability	□ Panic Attacks	□ Tearfulness
□ Bipolar	□ Guilt	□ Isolation	□ Paranoia	□ Worthlessness
□ Binge Eating	□ Hallucinations	□ Mania	□ Parkinson's	
□ Concentration is poor	□ Other, please explain:_____			

_____

_____

_____

STRESSORS:

□ Disability	□ Family	□ Housing Problems	□ Peer/ Friendship
□ Divorce	□ Financial Problems	□ Limited Resources	□ Support System
□ Education Problems	□ Health Problems	□ Marriage	□ Work Issues

□ Other:_____

2. Psychiatric History:

Have you ever been treated for mental health/psychiatric conditions/psychotherapy? □ YES ↴ □ NO Next question #3

If YES, then answer the Inpatient and/or Outpatient Treatment History tables below. If NO, then skip to next question #3.

Inpatient

INPATIENT Psychiatric TREATMENT HISTORY IN HOSPITAL or PARTIAL HOSPITALIZATION:

Facility Name	Dates of Treatment	Reason or Explanation of this treatment
Name: City, State Phone ( ) - Fax ( ) -		
Name: City, State Phone ( ) - Fax ( ) -		

OUTPATIENT

OUTPATIENT Psychiatric / Mental Health / Psychotherapy TREATMENT HISTORY:

Psychiatrist / APRN / Therapist / Other Mental Health	Dates of Treatment	Reason or Explanation of this treatment
Name: City, State Phone ( ) - Fax ( ) -		□ Medication Management to treat_____ □ Psychological Testing □ Therapy(__Individual __Family __Group) □ Additional Explanation:
Name: City, State Phone ( ) - Fax ( ) -		□ Medication Management to treat_____ □ Psychological Testing □ Therapy(__Individual __Family __Group) □ Additional Explanation:
Name: City, State Phone ( ) - Fax ( ) -		□ Medication Management to treat_____ □ Psychological Testing □ Therapy(__Individual __Family __Group) □ Additional Explanation:

3. Substance Abuse History:

Have you ever been treated for alcohol or drug use and/or abuse? □ YES ↴ □ NO Next question #3a

If YES, then complete the Treatment History table below.

INPATIENT and/or OUTPATIENT SUBSTANCE ABUSE TREATMENT HISTORY:

Facility Name	Dates of Treatment	Reason or Explanation of this treatment
Name: City, State Phone ( ) - Fax ( ) -		
Name: City, State Phone ( ) - Fax ( ) -		

3a. Complete the table below regarding the following substances:

Substance	Have you ever tried before?	Age Started	Last used on this approx. date	Frequency of use	Lost Control?	Comments
Caffeine (coffee,tea,cola's)	□ Yes □ No					
Cigarettes, cigars or tobacco	□ Yes □ No					If you quit smoking, when did you quit?
Cocaine	□ Yes □ No					
Hallucinogens (LCD, mushrooms, Mescaline)	□ Yes □ No					
Heroin	□ Yes □ No					
IV Drug use	□ Yes □ No					
Marijuana	□ Yes □ No					
Medical Marijuana	□ Yes □ No				If currently using medical marijuana, what doctor or facility do you go for treatment?	
Pain Pills	□ Yes □ No					
Other:	□ Yes □ No					

3b.) Alcohol Use:

Have you ever tried before? □ Yes (then continue additional questions below) □ No (then continue to next Section-**3c**)

What age did you start alcohol use? _____ When did you last drink alcohol? _____

How often do you have a drink containing alcohol? □ Never □ Monthly or less □ 2-4 times a month □ 2-3 times a week □ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day? □ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more

How often do you have six or more drinks on one occasion? □ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

Periods of Abstinence:_____

Comments or more information about your alcohol history that you want to share?_____

_____

_____

3c.) Have you experienced any of the following withdrawal symptoms and on what substance(s)?

Withdrawal Symptom	Have you experienced?	What Substance(s)?
Anxiety	□ Yes □ No	
D.T's (delirium tremens)	□ Yes □ No	
Seizures	□ Yes □ No	
Sweating	□ Yes □ No	
Tremors	□ Yes □ No	
Tachycardia	□ Yes □ No	
Other:	□ Yes □ No	

SMOKING STATUS:

□ Current every day smoker □ Former smoker □ Never smoker □ Unknown current smoker

□ Current some day smoker □ Current smoker □ Unknown if ever smoked

4. Medical History:

Please check beside any illness/medical condition you have now or have had in the past:

□ Arthritis □ Chronic Pain □ Liver Disease □ Stomach Problems
□ Blood Disorders □ Diabetes □ Lung Disease/Breathing Problems □ Stroke
□ Bowel Problems □ Glaucoma/Vision Problems □ Migraines □ Thyroid Disease
□ Cancer □ Heart Attack □ Seizures / Epilepsy □ Ulcer
□ Chest Pain □ Hepatitis □ Other, please explain:_______________________________________
□ High Blood Pressure: Are you currently on medication for your high blood pressure? □ Yes □ No
□ High Cholesterol: Are you currently on medication for your high cholesterol? □ Yes □ No

Date of your most recent blood work? ______________________* **Where?** □ Labcorp □ Millennium Phys Lab □ Quest □ __________

*We kindly ask that you provide a copy of your most recent blood work lab results with this document or have them faxed to us.

Have you ever had an EKG? □ No □ Yes, When:_____________________ Was the EKG □ Normal □ Abnormal □ Unknown

SURGICAL PROCEDURES:

Type of Procedure	Date Occurred

SERIOUS INJURIES OR ACCIDENTS:

Type of Injury/Accident	Date Occurred

ALLERGIES:

Food / Medication Allergy	Type of Reaction

PAST PSYCHIATRIC ONLY MEDICATIONS YOU HAVE TRIED AND ARE NO LONGER TAKING:

Past Psychiatric Medications you have tried	Dose (mg: tablets or capsules) or other dose type	Frequency	Date Started	Date Stopped	Reason for Stopping
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed			
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed			
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed			
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed			
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed			
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed			
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed			
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed			
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed			

COMPLETE LIST OF ALL CURRENT MEDICATIONS: (Use the table below or if you have a current list, please print off and attach with this form or download our **Complete Med list form** available on our website, www.cornerstonepsychiatric.com under Patient Forms).

Current Medications	Dose (mg, ml, etc..)	Frequency	Last dose taken
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed	
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed	
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed	
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed	
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed	
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed	
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed	
	□ **mg** (__TAB __CAP)	___x day or | □ AM □ PM □ As needed	

Have you ever discontinued or altered the prescribed dose of your medication without the recommendation of your treating physician? □ YES □ NO If YES, please explain:____

5. Family History

Has anyone in your family ever been treated for any of the following? Place and 'X' where appropriate.

Illness	Father	Mother	Brother	Sister	Children	Aunt		Uncle		Grandparent	
						Father's side	Mother's side	Father's side	Mother's side	Father's side	Mother's side
ADHD											
Alzheimer's Disease											
Anxiety / Panic Attacks											
Bipolar Disorder											
Depression											
Heart Disease											
Schizophrenia											
Seizures											
Stroke											
Substance Abuse											
Suicide Attempts											

NUTRITIONAL ASSESSMENT: Height:_____ Current Weight:_____

Without wanting to, have you lost / gained more than 10 pounds within the last 6 months? □ YES □ NO

If YES, Amount Weight Lost:_____ Amount Weight Gained:_____

Sleep Patterns: Hours each night: _____ □ Awakens Frequently □ Difficulty returning to sleep □ Difficulty falling asleep

FUNCTIONAL ASSESSMENT:

Have you experienced a recent loss of independence in caring for yourself? □ YES □ No

If YES, please explain:_____

FOR WOMEN ONLY:

Date of last menstrual period:_____.

Are you currently pregnant? □ YES □ NO Are you planning to get pregnant in the near future? □ YES □ NO

Birth control method:_____

Comments—In your own words, please describe why you have sought services with us?

_____

_____

_____

_____

Any other additional information you care to share with us?

_____

_____

_____

_____

_____