

# Patient Intake Form

Appointment Date and Time: \_\_\_\_\_

Patient Account#: \_\_\_\_\_



## Cornerstone Psychiatric Services, Inc.

David Donahue, D.O. ♦ David Fawks, APRN ♦ Kristoffer Guerrero, APRN  
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1790 E Venice Ave. Ste. 204, Venice, FL 34292  
Phone: (941) 488-8884 Fax: (941) 488-5554

### For CPS Office Use:

Intake  Insurance  Photo ID  ROI

## 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  
 Separated for \_\_\_\_ years  Single for \_\_\_\_ years  Widowed for \_\_\_\_ years  
 Birth Gender:  Male  Female  
 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: _____	(____) _____ - _____ <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>

## 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  Carelton 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  Carelton Behavioral (formerly Beacon Health)  Other: \_\_\_\_\_

**2<sup>nd</sup> Insurance ID#:** \_\_\_\_\_ **Group#** \_\_\_\_\_ **Plan:** \_\_\_\_\_ **COPAY (if known):** \_\_\_\_\_

**2<sup>nd</sup> 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, 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 and Kristoffer Guerrero 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](http://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?**

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

**STRESSORS:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Disability         | <input type="checkbox"/> Family             | <input type="checkbox"/> Housing Problems  | <input type="checkbox"/> Peer/ Friendship |
| <input type="checkbox"/> Divorce            | <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Limited Resources | <input type="checkbox"/> Support System   |
| <input type="checkbox"/> Education Problems | <input type="checkbox"/> Health Problems    | <input type="checkbox"/> Marriage          | <input type="checkbox"/> Work Issues      |
| <input type="checkbox"/> 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 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 ( ) -		<input type="checkbox"/> Medication Management to treat _____ <input type="checkbox"/> Psychological Testing <input type="checkbox"/> Therapy( __Individual __Family __Group) <input type="checkbox"/> Additional Explanation:
Name: City, State Phone ( ) - Fax ( ) -		<input type="checkbox"/> Medication Management to treat _____ <input type="checkbox"/> Psychological Testing <input type="checkbox"/> Therapy( __Individual __Family __Group) <input type="checkbox"/> Additional Explanation:
Name: City, State Phone ( ) - Fax ( ) -		<input type="checkbox"/> Medication Management to treat _____ <input type="checkbox"/> Psychological Testing <input type="checkbox"/> Therapy( __Individual __Family __Group) <input type="checkbox"/> Additional Explanation:

**3. Substance Abuse History:**

Have you ever been treated for alcohol or drug use and/or abuse?  YES 

NO  #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)	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Cigarettes, cigars or tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No					If you quit smoking, when did you quit?
Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Hallucinogens (LCD, mushrooms, Mescaline)	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No					
IV Drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Medical Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No					If currently using medical marijuana, what doctor or facility do you go for treatment?
Pain Pills	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
D.T's (delirium tremens)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sweating	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tremors	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tachycardia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed			
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed			
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed			
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed			
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed			
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed			
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed			
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed			
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed			
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> 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](http://www.cornerstonepsychiatric.com) under Patient Forms).

Current Medications	Dose (mg, ml, etc..)	Frequency	Last dose taken
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed	
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed	
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed	
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed	
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed	
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed	
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> As needed	
	<input type="checkbox"/> mg ( __ TAB __ CAP)	__ x day or <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> 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?

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Any other additional information you care to share with us?

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## Cornerstone Psychiatric Services, Inc.

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### HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (“HIPAA”) NOTICE OF PRIVACY PRACTICES (“NOTICE”)

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. FURTHER DETAILS INCLUDE HOW YOU OR YOUR PERSONAL REPRESENTATIVE MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

This Notice describes how **Cornerstone Psychiatric Services, Inc. “Cornerstone” (“Practice”)** and our health care providers, employees, volunteers, trainees and staff may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes that are described in this Notice. We understand that medical information about you and your health is personal, and we are committed to protecting medical information about you. This Notice applies to all records of your care generated by this practice and to substance use treatment-related records (SUD treatment records) under 42 U.S.C. §290dd-2 and 42 C.F.R. Part 2 (Part 2) that we receive or maintain. We also follow the confidentiality protections of Part 2 for such records. Certain uses and disclosures otherwise permitted by HIPAA are materially limited by Part 2.

This Notice also describes your right to access and control your medical information. This information about you includes demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will then be effective for all medical information that we maintain at that time and thereafter. We will provide you with any revised Notice if you request a revised copy be sent to you in the mail or if you ask for one when you are in the office.

**I. Uses and Disclosures of Protected Health Information (“PHI”).** Your medical information may be used and disclosed for purposes of treatment, payment and health care operations; provided, however, use or disclosure of SUD treatment records for payment and/or healthcare operations generally requires your written consent. The following are examples of different ways we use and disclose medical information. **These are examples only.**

**(a) Treatment.** We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other health care providers who may be treating you, such as a health care provider to whom you have been referred to, to ensure that the health care provider has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another health care provider, such as a laboratory.

**(b) Payment.** We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can decide of eligibility or to obtain prior approval for planned treatment, such as disclosing relevant medical information to the health plan to obtain approval for hospital admission.

**(c) Health\_Care Operations.** We may use or disclose medical information about you to support the business activities of our practice. These activities include, but are not limited to, reviewing our treatment of you, employee performance reviews, training of personnel, medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your health care provider. We can also call you by name in the waiting room when your health care provider is ready to see you. We may use or disclose your medical information to remind you of your next appointment. We may share your medical information with third party “business associates” that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms that asks the “business associate” to protect the privacy of your medical information. We may use or disclose your medical information to provide you with information about treatment alternatives, case management or other health-related benefits and services that may be of interest to you. We may also use and disclose your medical information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or a prescription refill reminder may be sent to you for a prescription you are currently prescribed or its generic equivalent. We may share your medical information with a pharmacist and/or pharmacy in order to dispense or approve a prescription to you. We may also send you information about products or services that we believe may be beneficial to you. You may contact our **Privacy Contact** to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your health care provider, as necessary, to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our **Privacy Contact** to request that these fundraising materials are not sent to you. If we intend to use or disclose records subject to 42 CFR part 2 for fundraising for the benefit of our practice, you will first be provided with a clear and conspicuous opportunity to elect not to receive any fundraising communications

**(d) Health\_Information Exchange.** We, along with certain other health care providers and practice groups in the area, may participate in a health information exchange (“**Exchange**”). An Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange, we may electronically disclose demographic, medical, billing and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, payment or health care operations.

**II. Other Permitted and Required Uses and Disclosures That May Be Made with Your Consent, Authorization or Opportunity to Object.** We may use and disclose your medical information in the following instances. You can agree or object to the use or disclosure of all or part of your medical information. If you are not present or able to agree or object to the use or disclosure of the medical information, then your health care provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the medical information that is relevant to your health care will be disclosed.

**(a) Others\_Involved in Your Health Care.** Unless you object, we may disclose to a member of your family, a relative or close friend your medical information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your medical information to an entity assisting in

disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**(b) Emergencies.** We may use or disclose your medical information for emergency treatment. If this happens, we shall try to obtain your consent as soon as reasonable after the delivery of treatment. If the practice is required by law to treat you and has attempted to obtain your consent but is unable to do so, the practice may still use or disclose your medical information to treat you. We may disclose your medical information to members of your family or others who can help you when you are sick, injured, in a crisis or after you are deceased.

**(c) Communication Barriers.** We may use and disclose your medical information if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and, in our professional judgment, you intended to consent to use or disclosure under the circumstances.

### **III. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent,**

**Authorization or Opportunity to Object.** We may use or disclose your medical information in the following situations without your consent or authorization. These situations include:

**(a) Law Enforcement.** We may use or disclose your medical information when federal, state or local law requires disclosure. You will be notified of any such uses or disclosure.

**(b) Public Health.** We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury or disability.

**(c) Communicable Diseases.** We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**(d) Health Oversight.** We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government agencies to oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**(e) Abuse or Neglect.** We may disclose your medical information to a public health authority that is authorized by law to receive reports of child / elder abuse or neglect. In addition, we may disclose your medical information to the governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence as is consistent with the requirements of applicable federal and state laws.

**(f) Food and Drug Administration.** We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**(g) Legal Proceedings.** We may disclose medical information during any judicial or administrative proceeding, when required by a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request or other lawful process.

**(h) Law Enforcement.** We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material

witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and (vi) responding to a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

**(i) Coroners, Funeral Directors, and Organ Donors.** (We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.

**(j) Research.** We may use and disclose your medical information for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board ("IRB") or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

**(k) Criminal Activity.** Consistent with applicable federal and state laws, we may disclose your medical information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**(l) Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**(m) Military Activity and National Security.** If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veterans Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the protective services to the President or others legally authorized.

**(n) Workers' Compensation.** We may disclose your medical information as authorized to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illness.

**(o) Inmates.** We may use or disclose your medical information if you are an inmate of a correctional facility and our practice created or received your health information while providing care to you.

**(p) Required Uses and Disclosures.** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500, et seq.

**(q) Imminent Threat to Health and Safety.** As allowed by law, we may make disclosures of medical information if we believe you pose a risk to your own health and safety or the health and safety of another person.

#### **IV. The Following Is a Statement of Your Rights with Respect to Your Medical Information and a Brief Description of How You May Exercise These Rights.**

**(a) You have the right to inspect and copy your medical information.** This means you may inspect and obtain a copy of medical information about you that has originated in our practice. We may charge you a reasonable fee for copying and mailing records. To the extent we maintain any portion of your PHI in electronic format, you have the right to receive such PHI from us in an electronic format. We will charge no more than actual labor cost to provide you electronic versions of your PHI that we maintain in electronic format. After you have made a written request to our Privacy Contact at the address designated below, we will have thirty (30) days to satisfy your request. If we deny your request to inspect or copy your medical information, we will provide you with a written explanation of the denial. You may not have a right to inspect or copy psychotherapy notes. In some circumstances, you may have a right to have the decision to deny you access reviewed. Please contact **Privacy Contact** if you have any questions about access to your medical record.

**(b) You have the right to request a restriction of your medical information.** You may ask us not to use or disclose part of your medical information for the purposes of treatment, payment or health care operations. You may also request that part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must state in writing the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict information sent to your health plan or insurer for products or services that you paid for solely out-of-pocket and for which no claim was made to your health plan or insurer.

**(c) We are not required to agree to your request.** If we believe it is in your best interest to permit use and disclosure of your medical information, your medical information will not be restricted; provided, however, we must agree to your request to restrict disclosure of your medical information if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the information pertains solely to a health care item or service for which you (and not your health plan) have paid us in full. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. Your written request must be specific as to what information you want to limit and to whom you want the limits to apply. The request should be sent, in writing, to our Privacy Contact.

**(d) You have the right to request to receive confidential communications from us at a location other than your primary address.** We will try to accommodate reasonable requests. Please make this request in writing to our Privacy Contact.

**(e) You may have the right to have us amend your medical information.** If you feel that medical information we have about you is incorrect or incomplete, you may request we amend the information. If you wish to request an amendment to your medical information, please contact our Privacy Contact. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

**(f) You have the right to receive an accounting of disclosures we have made, if any, of your medical information.** This applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice. It excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time no longer than six (6) years and after April 14, 2003, please submit your request in writing to our Privacy Contact. We will notify you in writing of the cost involved in preparing this list. To the extent we maintain your PHI in electronic

format, you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or health care operations for the preceding three (3) years prior to such request.

**(g) Uses and Disclosures of Protected Health Information Based upon Your Written Authorization.** Other uses and disclosures of your medical information not covered by this Notice or required by law will be made only with your written authorization. For example, the following uses and disclosures require your authorization: (1) Most uses and disclosures of psychotherapy notes; (2) Uses and disclosures of PHI for marketing purposes unless the communication (i) occurs face-to-face; (ii) consists of marketing gifts of nominal value; (iii) is regarding a prescription refill reminder that is for a prescription currently prescribed or a generic equivalent; (iv) is for treatment pertaining to existing condition(s) and we do not receive any financial remuneration in either cash or cash equivalent; and/or (v) communication from us to recommend or direct alternative treatments, therapies, health care providers or settings of care when we do not receive any financial remuneration for making the communication; and (3) Disclosures that constitute a sale of PHI and other than those described in this Notice, require authorization. You may revoke this authorization at any time, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the prior authorization.

**(h) Right to be Notified of a Breach.** You have the right to be notified if our practice (or a Business Associate of ours) discovers a breach of unsecured protected health information.

**(i) Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated, as follows: U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>. You may file a complaint with us by notifying our Privacy Contact in writing. We will not retaliate against you for filing a complaint.

**(j) Redisclosure:** Information that is disclosed to third-parties pursuant to the HIPAA Privacy Rule is subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

**IV. State Law.** Applicable state law(s) may have certain requirements that govern the use or disclosure of your PHI. For us to release information about mental health treatment, genetic information, your AIDS/HIV status, alcohol or drug abuse treatment, or other specific medical information or conditions, you may be required to sign an authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

**V. Applicability.** This Notice and the obligations of Practice herein shall apply only to the extent that the information to be created, used and/or disclosed by Practice is PHI (as defined by HIPAA) and subject to HIPAA protections. By providing this Notice, Practice is neither conceding nor admitting that any such information qualifies as PHI.

**VI. Substance Abuse Treatment.** We are required to protect the privacy and security of your substance use disorder patient records in accordance with 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2, the Confidentiality of Substance Use Disorder Patient Records (“**Part 2**”), in addition to HIPAA and applicable state law. In a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your SUD treatment records unless a court order requires us to do so (after notice and an opportunity to be heard is provided to you, as provided in 42 CFR part 2) or you give us your written permission. You may report suspected violations to the U.S. Attorney for the judicial district in which the violation occurs. Contact information for the U.S. Attorney office where we operate is below:

Office of The State Attorney, 12<sup>th</sup> Judicial Circuit

Sarasota Office – Criminal Justice Building

2071 Ringling Blvd. Ste 400, Sarasota, FL 34237

Phone: (941) 861-4400 Fax: (941) 861-4465

Suspected violations by an opioid treatment program may be reported to the Substance Use and Mental Health Services Administration (SAMHSA), Opioid Treatment Program Compliance Office by phone at 204-276-2700 or online at OTP-extranet@opioid.samhsa.gov.

## Contact Information

**Privacy Officer:** Brad Labath, Address: 1790 E. Venice Ave. Ste. 204, Venice, FL 34292

**Phone:** (941) 488-8884 **Fax:** (941) 488-5554

### To File a Complaint with HHS:

Office for Civil Rights, U.S. Department of Health and Human Services

200 Independence Avenue, S.W., Washington, D.C. 20201

Phone: 1-877-696-6775 Website: [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

## ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have offered and/or received a copy of **Cornerstone Psychiatric Services, Inc.** Notice of Privacy Practices.

**Patient Name (Print) :** \_\_\_\_\_

**Patient Signature :** \_\_\_\_\_

**Date:** \_\_\_\_\_

*If signed by personal representative, please describe relationship to patient and authority to act on patients' behalf:*

\_\_\_\_\_

## FOR OFFICE USE ONLY

If acknowledgment is not obtained, document reason:

Emergency situation

Patient refused to sign

Other: \_\_\_\_\_

Staff Initials: \_\_\_\_\_ Date: \_\_\_\_\_