Cornerstone Coordinated Healthcare, LLC

Registration form

Patient Information

Salutation:_____ Last Name: _____First Name:_____

Middle Suffix:_____ Date of Birth:_____Gender:_____

SSN:_____Marital Status:_____Street 1:_____

City:_____State:_____Zip:_____Email:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Language Preference: English: _____ Spanish: _____ Other: _____

Race:

Refused: _____
White: _____
White Hispanic or Latino: _____
Black or African American: _____
Black Hispanic or Latino: _____
American Indian or Alaska Native: _____
Native Hawaiian: _____
Filipino: _____

Chinese: _____
Japanese: _____
Korean: _____
Other Asian: _____
Other Pacific Islander: _____
Vietnamese: _____
Unknown: _____

Ethnicity: Hispanic or Latino: _____ Not Hispanic or Latino: _____ Refused: _____

Employer/School Name:_____ Preferred pharmacy:_____

Contact Preference:_____ Preferred Provider:_____

Primary Insurance Plan:_____ID. #:_____Group #:_____

How did you hear about us?

Advertisement: _____
Doctor (Who?): _____
Other: _____

Patient: _____
Yellow Pages: _____

Guarantor Information

SSA:_____(If patient is not the Guarantor then complete this section.)

Salutation:_____ Last Name: _____First Name:_____

Middle Suffix:_____ Date of Birth:_____Gender:_____

SSN:_____Marital Status:_____Street 1:_____

City:_____State:_____Zip:_____Email:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Employer/School Name:_____ Preferred pharmacy:_____

Contact Preference:_____ Preferred Provider:_____

Primary Insurance Plan:_____ID. #:_____Group #:_____

Cornerstone Coordinated Health Care, LLC.
General Consent

1. I have presented myself for treatment to Cornerstone Coordinated Health Care, LLC's facility and consent to routine medical care provided by the facility. I acknowledge that because medicine is not an exact science, no guarantees or warranties can be mad to me regarding the results of any treatment in this facility.
2. I understand that this consent does not include informed consent for operations or any non-routine procedures or treatment and that the risks and alternatives for such procedures or treatment, which as reasonable patient would consider significant to a decision whether or not to undergo such treatment of procedures, will be explained to me by my treating provider or another provider designated by him/her. I understand I have the right to refuse any drugs, treatment or procedure to the extent permitted by law.
3. I authorize the facility to use and disclose my health information: (1) to other health care professionals who are involved in my treatment, either now or in the future; (2) to any insurance company or other entity as necessary for the facility to be paid for the services provided to me; and (3) for the general administrative activities of the facility, such as quality control and peer review.
4. I have provided the facility with my true and correct medical insurance information and I hereby assign and transfer to the facility all medical provider benefits payable and any related rights existing under those insurance policies. I authorize and direct the insurance company to pay all such benefits to the facility. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and the facility.
5. I understand that this facility is a teaching facility or is on that supports professional education training, that those involved in training programs may be participating in my care, and I consent to their presence and participation in my care.
6. I have been advised no to keep valuables on my person, leave them in the waiting room, or in my examination room. I will not hold the facility responsible for any valuables that I keep on my person or bring into the facility.
7. I hereby authorize the facility to dispose of all tissue, blood, and other organic matter in the facility's normal and routine method of disposing of such matters, including the use of blood and tissue for the internal purpose of gathering and sorting data, or human tissue by categories to be available for potential use in research studies. If my information is to be used for a research study, I may be asked to sign additional authorization at that time.
8. I have the right to file a grievance in writing or in person to administration. If the grievance is not resolved to my satisfaction, I may contact one of the organizations: Pennsylvania Department of Health (800-254-5164) or Quality Insights of Pennsylvania (800-322-1914).
9. **Medicaid Patients:** My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false clams, statements, documents, or concealments or material may be prosecuted under applicable Federal and State laws.
10. You have the right to choose a visitor who may accompany you during your treatment regardless of whether the visitor is a family member, friend or domestic partner. You have the right to change or withdraw your visitor's privileges at any time by notifying the office staff.

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND COMPLETELY THE INFORMATION ON THIS CONSENT; THAT ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION AND ANY STATEMENTS NOT APPLICABLE HAVE BEEN CROSSED OUT AND INTIALED PRIOR TO MY SIGNATURE.

PATIENT SIGNATURE _____ DATE _____ TIME _____ PATIENT PRINTED NAME _____

SIGNATURE OF AUTHORIZED PERSON/LEGAL GUARDIAN _____ DATE _____ TIME _____ RELATIONSHIP _____

PRINT NAME OF AUTHORIZED PERSON/LEGAL GUARDIAN _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED A COPY OF THE CORNERSTONE COORDINATED HEALTH CARE, LLC NOTICE OF PRIVACY PRACTICES

SIGNATURES _____

PRINT NAME _____

DATE _____

Insurance Information

Primary Insurance:_____

Subscriber Name:_____ Sex:_____ Date of Birth:_____

Patient Relationship to Insured:_____ Policy Number:_____

If workman's Comp/Auto-Claim Number:_____

Group Number:_____ Insurance Phone Number:_____

*If insurance card lists address to bill or this claim is a workman's Comp or auto claim please complete:

Address (to bill claims) :_____ City:_____

State:_____ Zip:_____ Adjustor Name:_____

Adjustor Phone Number:_____

Secondary Insurance:_____

Subscriber Name:_____ Sex:_____ Date Of Birth:_____

Patient Relationship to Insured:_____ Policy Number:_____

Group Number:_____ Insurance Phone Number:_____

Signature:_____

Date:_____

Notice of Financial Policy Acknowledgment

I HAVE RECEIVED A COPY OF THE CORNERSTONE COORDINATED HEALTH CARE, LLC NOTICE OF FINANCIAL POLICIES AND PROCEDURES

SIGNATURE_____

PRINT NAME _____

DATE _____

CORNERSTONE COORDINATED HEALTH CARE, LLC.

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

Date of Birth: _____

CORNERSTONE COORDINATED HEALTH CARE, LLC is authorized to **furnish to / receive from** (circle desired choice):

Recipient/Discloser: _____

For the Purpose of : _____
(optional)

_____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- ☐ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

- ☐ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

_____

_____

I release Cornerstone Coordinated Health Care, LLC., and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Cornerstone Coordinated Health Care, LLC., provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ____/____/____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____
Patient Signature (Parent's Representative if minor) Date

_____ _____
Witness Signature Date

So that we may improve our patient care, please let us know the reason you are requesting this record release (check all that apply):

- ☐ Not satisfied with Provider (which provider? _____)
- ☐ Not satisfied with Staff (which staff member? _____)
- ☐ Moving out of the area?
- ☐ Other (Please describe :_____)

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