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|----------------------|---------------------|---------------------|--------------|------------------------|
| Patient Last Name: | Patient First Name: | M.I.: | Maiden Name: | Date of Birth: |
| Social Security#: | Marital Status | Spouse/Parent Name: | | Spouse/Parent Phone #: |
| Home Phone #: | Cell Phone# | Employer/School: | | Work Phone#: |
| Home Street Address: | Apt# | City | State | Zip: |
| Preferred Pharmacy: | Pharmacy Phone: | Pharmacy Location: | Email: | |

Required Insurance Information: All Information Must Be Provided

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|-------------------------------------|--------------------------|---------------------------|------------------------------|
| Primary Insurance Company: | Subscriber Name: | Subscriber Address: | Subscriber Date of Birth: |
| | Relationship to Patient: | | |
| ID Number (Policy Number): | Group Number: | Insurance Company Phone#: | Subscriber Social Security # |
| Secondary Insurance Company: | Subscriber Name: | Subscriber Address: | Subscriber Date of Birth: |
| | Relationship to Patient: | | |
| ID Number (Policy Number): | Group Number: | Insurance Company Phone#: | Subscriber Social Security # |

****REQUIRED: Please review and initial beside each policy item****

I certify that the information I have provided is true to the best of my knowledge. I understand it is my responsibility to keep my insurance, phone number and address current and will contact Cornerstone Primary Healthcare with updates as they occur.

I authorize my insurance benefits to be paid directly to the provider. I understand I am responsible for knowing my insurance plan and coverage/exclusions. **Cornerstone Primary Healthcare is NOT contracted with MEDICAID or TENNCARE.** CPH may also be excluded from other insurance plans.

Some Insurance Companies allow us to do a Physical (Wellness) and sick/refill/problem visit on the same day but, we are required to submit a separate office visit charge. **A Sick/Refill/Problem Visit is NOT covered under the Wellness Benefit and copays/deductibles will apply.**

I understand that I am financially responsible for any balance/Copay that was NOT covered by my insurance and assigned to me.

I am aware that Cornerstone Primary Healthcare will collect all co-pays/deductibles and balances prior to being seen. I understand if I cannot pay my copay/balance, I will be asked to reschedule my appointment. I understand all monies are due regardless of if a statement/notification was received. I understand a copy of the receipt/statement will be provided if requested.

I am aware that if I do not have proof of valid insurance that full payment is expected at the time of service.

I understand that a **\$45.00** fee will be charged each time medical forms are completed (excluding Biometric Forms).

I am aware that if I fail to show for an appointment a **\$45.00** fee per missed appointment will be charged to my account. A 24-hour notice must be given to reschedule or cancel my appointment, or I will be charged a **\$45.00** fee.

I understand that the automated appointment reminders are a courtesy and not receiving one does not excuse me from missing my appointment.

Two missed appointments or two appointments cancelled/rescheduled same day, may result in my dismissal from the practice.

One statement will be mailed to address on file. TEXT notifications will follow for all past due accounts. A 5% late fee will be charged to any balance remaining after 30 days.

Ignoring my bill or not having current contact information on file will cause a delinquency in my account therefore resulting in aggressive collection done by a third party. The collection fees (30%) incurred will be an additional charge for which I am responsible.

I understand that if I transfer care or I am dismissed for any reason, I will no longer be a patient of CPH. I understand once dismissed/transferred from practice; I will not be allowed to schedule any appointments with my provider and all future appointments will be cancelled.

It is the Policy of Cornerstone Primary Healthcare to contact patients by phone and if needed leave a voice mail. The voice mail may contain information concerning appointments, test results, referral appointments and outstanding balances. If no VM is set up or if full, a text message will be sent instead. Leaving a message on my phone/cell phone and receiving text messages is acceptable to me.

I have reviewed the CPH Patient Portal Policy. I understand that my lab/Imaging results will be uploaded to the portal for my review. I understand that **printed copies will no longer be provided.** IF I choose not to use the portal, I understand that an appointment will be required to discuss these results.

Email for the Patient Portal _____
 (EMAIL Address Provided Can Not Be Used/Shared with Another Patient)

 Patient/ Guardian Signature Date