*Note: If you do not bring insurance card please be prepared to pay when services are rendered.*

Appt Date: _____
Appt Time: _____

| | | | |
|---|---|---|---|
| ☐ Kay Chandler, MD | ☐ Kenneth Singleton, MD | ☐ Kevin Breniman, MD | ☐ Matthew Sellers, MD |
| ☐ Jennifer Anderson, MD | ☐ Nathan Livers, MD | ☐ Lisa Grummer, APRN | ☐ Rachel Ashcraft, APRN |
| ☐ Kristen Bracy, MD | ☐ Christa Jackson, APRN | ☐ Jennifer Wilson, APRN | ☐ Lindsey Galloway, APRN |
| ☐ Megan Tucker, APRN | ☐ Sarah Holland, APRN | ☐ Robin Koontz, APRN | ☐ Angela Titus, APRN |

# Cornerstone Clinic for Women

## PATIENT INFORMATION

PLEASE PRINT

Name _____
(Last) (First) (MI)
Address _____
Street, Highway, P.O. Box, and Apt #
_____
City State Zip
Home Phone _____ Age: _____
Work Phone _____ Cell_____
SSN#_____DOB _____
Email Address _____
Patient Employer _____
Employer Address _____
☐ Send Appointment Reminders by Text Message

PLEASE PRINT

Child ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐
Separated ☐ Male ☐ Female ☐ Race _____
Referring Physician _____
Primary Care Physician _____
Spouse Name _____
Spouse SSN#_____ Spouse DOB _____
Spouse Employer _____
Employer Address_____
Closest Relative (other than spouse) _____
Address_____
Relationship_____
Phone _____
☐ I want to use CCFW's Patient Health Portal to receive my Lab Results, Exam Summary & Plan and Medication Requests

## INSURANCE INFORMATION

Primary Carrier_____
Address for Claims_____
_____
Carrier's Phone # _____
ID/Policy # _____
Group # _____

Second Carrier _____
Address for Claims _____
_____
Carrier's Phone # _____
ID/Policy #_____
Group #_____

## IF ON PARENT'S INSURANCE, PLEASE FILL OUT

Father/ Guardian _____
Home Address_____
(If Different From Patient)
Employer _____
Address _____
SSN# _____ DOB _____
Work Phone _____ Cell_____

Mother / Guardian _____
Home Address _____
(If Different From Patient)
Employer _____
Address _____
SSN# _____ DOB _____
Work Phone _____ Cell _____
Person to Bill_____

## Consent and Authorization

I request that payment of insurance benefits be made on my behalf to Cornerstone Clinic for Women for any services furnished to me by any physician in the clinic. I authorize any holder to release any personal medical information needed to determine benefits to my insurance carrier, and where applicable, I further authorize the clinic, its agents or its assignees to verify employment, wage or other data as considered necessary.

_____ _____
Signature of patient or Authorized Representative Date

The signature below acknowledges a copy of this notice; Patient Privacy Practices was RECEIVED (not necessarily read).
(You may receive/read this on www.cornerstoneclinicforwomen.com and it is also available when you check in for you appointment)

_____/_____/_____ _____
Date Patient or Legal Representative

**Message Consent**: The Cornerstone Clinic for Women is dedicated to providing you fast and reliable information concerning your care. In many cases, we may not be able to talk to you directly because you may be away from your telephone. A convenient alternative is to leave a message or a text for you to check later. However, voice messages ***may contain*** confidential issues. *Text messages will only contain information concerning appointments and weather related announcements only* and ***will not contain*** private patient health information. Please indicate your wishes below by simply **initialing and checking** one or more of the following choices. If you do not have any of the devices below, simply leave them blank.

**NOTE: By checking one or more of the boxes below I authorize the staff of Cornerstone Clinic for Women to leave or transmit important and potential confidential information to one or more of the following:**

_____ ☐ **Answering machine** at the home telephone number _____.

_____ ☐ **Voice mail** at the work number ***only*** if the voice mail message has your name _____.

_____ ☐ **Voice mail** at the **cell phone** _____.

_____ ☐ **Text message** to your **cell phone** _____.

*****Do you check messages regularly? Yes No**

*NO ONE WILL BE ABLE TO ACCESS INFORMATION ABOUT YOU EXCEPT YOU, UNLESS YOU FILL OUT THE BELOW ADDENDUM.*

## **ADDENDUM:** PATIENT PRIVACY

I _____ authorize Cornerstone Clinic for Women to share pertinent "Protected Health Information" with my immediate family members or significant others, as noted below:

1. _____ _____ _____/_____/_____ ☐Allow Access for Patient Health Portal
Print the Name Clearly Relationship Date

_____ _____
Telephone Number Alternative Number

2. _____ _____ _____/_____/_____ ☐Allow Access for Patient Health Portal
Print the Name Clearly Relationship Date

_____ _____
Telephone Number Alternative Number

3. _____ _____ _____/_____/_____ ☐Allow Access for Patient Health Portal
Print the Name Clearly Relationship Date

_____ _____
Telephone Number Alternative Number

**I understand** that I may withdraw the above authorization at any time, with **written** request. I also understand that it is my responsibility to inform all family members or significant others to not disclose or use this information at any time or in any way without my permission.

_____ _____/_____/_____
MINOR SIGNATURE AGE 17 AND YOUNGER DATE

_____ _____/_____/_____
ADULT SIGNATURE DATE