

PATIENT'S PERSONAL INFORMATION

Marital Status: Single Married Divorced Widowed Sex: Male Female

Preferred Language: _____ Email Address: _____

Name: _____
last name first name initial

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Race: Asian Black/African American American Indian/Alaskan Native Hispanic White More than one race Decline To Answer

Ethnicity: Hispanic/Latino NOT Hispanic/Latino Decline to Answer

Reporting of race & ethnic group is a government requirement under the American Recovery and Reinvestment Act of 2009.

RESPONSIBLE PARTY INFORMATION IF NOT SELF

Relationship to Patient: Spouse Child Other: _____

Name: _____
last name first name initial

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Insurance cards or proof of insurance must be presented to receptionist at each visit.

PRIMARY Insurance Name: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: Self Spouse
 Child Other

Policy #: _____ Group #: _____ Copay: \$ _____

SECONDARY Insurance Name: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: Self Spouse
 Child Other

Policy #: _____ Group #: _____ Copay: \$ _____

PATIENT'S EMPLOYER

Name: _____ Occupation: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

SPOUSE'S INFORMATION

Spouse's Name : _____ Contact No: _____

Employer's Name: _____ Occupation: _____

Employer's Phone: (____) _____

EMERGENCY CONTACT

Someone other than spouse and not living with you.

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

I hereby state that the above information is true and correct to the best of my knowledge.

SIGNATURE X _____
Signature of Patient or Patient's Legally Authorized Representative

DATE

Printed Name of Patient's or Patient's Legally Authorized Representative: _____

If representative, specify relationship to the patient: Parent Guardian Other _____

Signatures Required on Reverse Side of Form ⇨

General Consent for Care and Treatment

Assignment of Benefits & Authorization to Release Information

Consent to Examine and/or Treatment

As a patient you have the right to be informed about your condition and recommended surgical, medical or diagnostic procedures. It will help you make an informed decision about undergoing further treatment or procedures and the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. I understand this consent will remain fully effective until it is revoked by me in writing to Cornerstone Clinic. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your healthcare provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician and/or mid-level provider (Nurse Practitioner/Physician Assistant), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that a Nurse Practitioner/Physician Assistant is a licensed healthcare provider who may only treat and diagnose any illness or medical conditions under the supervision of a licensed physician. The "supervision" of the Nurse Practitioner/Physician Assistant is done in accordance with the rules of the Texas Medical Board.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

SIGNATURE X _____
Signature of Patient or Patient's Legally Authorized Representative Patient Date of Birth Date

Printed Name of Patient or Patient's Legally Authorized Representative: _____

If representative, specify relationship to patient: Parent Guardian Other _____

Assignment of Benefits and Authorization to Release Information

I hereby assign, transfer and set over to **Fredericksburg Family Clinic, PA dba Cornerstone Clinic** all of my rights, title and interest to mine or my dependents medical reimbursement benefits under my insurance policy, including Medicare, Medicap and/or Medicaid benefits. I hereby authorize **Cornerstone Clinic** to release any information necessary to insurance company regarding my illness and treatments. I understand claims will be filed electronically or on paper claims forms and submitted to my insurance company for services rendered. I understand this assignment will remain in effect until revoked by me in writing to Cornerstone Clinic. I agree a photocopy of this authorization is valid.

I have read Cornerstone Clinic's Financial Policy and understand that I am financially responsible for any unpaid deductible and/or co-payments that are due at the time services are rendered. Charges not payable or not covered by my insurance plan are my responsibility.

SIGNATURE X _____
Signature of Patient or Patient's Legally Authorized Representative Patient Date of Birth Date

Printed Name of Patient or Patient's Legally Authorized Representative: _____

If representative, specify relationship to patient: Parent Guardian Other _____