FREDERICKSBURG FAMILY CLINIC, P.A.
d/b/a CORNERSTONE CLINIC

PATIENT REGISTRATION FORM FOR ADULTS

Please PRINT AND complete ALL sections below!

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_____

FREDERICKSBURG FAMILY CLINIC, PA
d/b/a/ CORNERSTONE CLINIC

514 W. WINDCREST ST., FREDERICKSBURG, TX 78624, 830.997.0330
815 FRONT ST., COMFORT, TX 78013, 830.995.5633

Patient Name:_____ **Date of Birth:**_____

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION (PHI)
Effective September 23, 2013, Revised July 2015

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice **before** signing this consent and prior to any service being provided to you by the practice. The Practice reserves the right to change the Notice of Privacy Policies. If we change our notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer or by asking the provider's receptionist. You can also obtain a copy on the clinic's website at www.cornerstoneclinicfbg.com.

I authorize Physicians/staff of CORNERSTONE CLINIC to release information pertaining to my condition and/or care to those individuals listed below:

	Full Name	DOB		Full Name	DOB
Spouse:			Children:		
Parent:					
Children:			Other:		

CORNERSTONE CLINIC physicians/staff may contact me in the following manner (check all that apply):

HOME TELEPHONE NO:_____
- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with family member
  Who? _____

CELLULAR TELEPHONE NO:_____
- ☐ OK to leave message on voicemail with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to receive text message

WORK TELEPHONE NO:_____
- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with co-worker
  Who?_____

WRITTEN COMMUNICATION
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number_____
  ***See fax policy below.**

Cornerstone Clinic is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of faxing, third parties may have access to messages. When communicating from work, you should be aware that some companies consider faxes corporate property and your messages may be monitored. I understand that this office will not be responsible for information loss or delayed, or breaches in confidentiality that are due to technical factors beyond this clinic's control. **I understand and agree to this fax policy**. _____(initial)

By signing this form, you acknowledge that you have been given the opportunity to read the clinic's Notice of Privacy Practices prior to any service being provided to you by this Practice, and you consent to the use and disclosure of your medical information to other healthcare providers involved in your care and for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH).

Signature of Patient/Legal Representative	Print Name	Date

If Legal Representative, relationship to Patient:_____

Please notify receptionist if you want a copy of this signed form for your records.