CORNERSTONE FAMILY HEALTHCARE

Patient Registration Form
Revised 5/2023

Patient Information

Patient's Legal Name: Last, First, MI		Preferred Name:	Today's Date:
Date Of Birth: (mm-dd-yyyy)	Gender Assigned at Birth: F: ☐ M: ☐	Mother's Maiden Name:	Preferred Language (incl. American sign Language-ASL): ☐ Requires Translation _____
Home Address:			
City:	State:	Zip:	**Phone Numbers**
Mailing Address: (If different from home address)			1. Home #
City:	State:	Zip:	2. Cellphone #

Preferred: ☐ Home ☐ Cellphone | Best time to call preferred contact # (please select 1 option): ☐ Morning ☐ Afternoon ☐ Evening

Email Address for Patient Portal:
*Must be 18 years of age or older

Insurance Information	Pharmacy (Name & Phone Number)
Name of Insurance:	1.
Insurance ID:	2.

My Doctor

Primary Care Provider Name (PCP):	PCP Address:

GETTING TO KNOW YOU

We require the following information for the purpose of understanding our population better and to satisfy our reporting requirements to the federal government. The options for these questions were provided by those organizations which analyze this information, and in no way impact the care you receive. Please help us serve you better by selecting the best answer to these questions. Thank You.

Income:	Veteran Status:
Total # of people living in household, including yourself: _____ Anticipated annual household income for this year: $ _____	Are you a veteran of the U.S. Military? ☐ Yes ☐ No

Migratory/Seasonal Worker

Within the last 24 months (including the present), have you had employment as an agricultural/farm worker? ☐ Yes ☐ No
If Yes: ☐ Seasonal ☐ Migrant

Housing Status

☐ I live in my own apartment/home, which is my permanent residence

☐ I permanently joined households with someone/another family (stable, permanent residence such as foster care, group home, or halfway house/living long-term with extended family members)

☐ I temporarily joined households with someone/another family (not a stable residence/not permanent/ may be at risk of losing nighttime residence/ not paying rent) Doubling-up

☐ I stay with different people in their homes and move around often from one house to another – transitional

☐ I live in a shelter ☐ I live in a hotel/motel

☐ I live in transitional housing (room or apartment in a residence with support services)

☐ I live either on the street/car/park/tent/abandoned building

Race & Ethnicity

Race (select one or more)

☐ Asian Indian	☐ Korean	☐ Other Pacific Islander	☐ American Indian/Alaska Native
☐ Chinese	☐ Vietnamese	☐ Guamanian or Chamorro	☐ White
☐ Filipino	☐ Other Asian	☐ Samoan	☐ More than one race
☐ Japanese	☐ Native Hawaiian	☐ Black/African American	☐ I decline to provide this information

Ethnicity (Select one)

☐ Mexican/Mexican American/Chicano(a)	☐ Another Hispanic, Latino(a) or Spanish Origin
☐ Puerto Rican	☐ Not Hispanic, Latino(a), or Spanish Origin
☐ Cuban	☐ I decline to provide this information

Sexual Orientation & Gender Identity:

Sexual Orientation (select one)		Gender Identity (select one)	
☐ Lesbian, gay or homosexual	☐ Don't know	☐ Male	☐ Transgender Female/Male to Female
☐ Straight or heterosexual	☐ Choose not to disclose	☐ Female	☐ Transgender Male/Female to Male
☐ Bisexual	☐ Something Else/Other	☐ Choose not to disclose	☐ Other

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Employment & Student Status

Employment (select one)		Student (select one)
☐ Full Time Employer Name: _____ ☐ Part Time ☐ Retired	☐ Active Military ☐ Reserved Military ☐ Unemployed ☐ Self Employed	☐ Full Time ☐ Part Time Name of School: _____ ☐ Not a student

Consent to Receive Messages

I will receive messages from Cornerstone Family Healthcare. Such text/voice messages may include appointment reminders, preventative/diagnosis related care reminders and health education materials. This excludes information to HIV, Substance Abuse & Mental Health.

☐ Ok to leave a voice message ☐ Ok to leave a text message (*MSG & data rates may apply) ☐ Opt out of all messages

Consent to Release Medical/Dental Information

I hereby give consent to the following individuals to have access and obtain copies of my medical/dental information. This includes health history, exam information, test and lab results. Information will be provided , based on my consent below.

Name: _____Phone #:_____Relation: _____

Name:_____Phone #:_____ Relation:_____

NOTE: While you are authorizing the above named person to have access to your records, they are not authorized access to sensitive information, such as HIV Status/Information, mental health information, State reportable results, and/or Alchohol & Substance information. If you wish to authorize access to those sensitive records, you must sign a sepaarate consent for each request.

Consent for Pediatric Patients

Parent/Guardian authorizes following individual to bring their child to Cornerstone Family Healthcare:

Name: _____ Relation:_____

Consent for Patient Portal

I authorize the following individual to have UNRESTRICTED access to my patient portal account. This includes access to all health information, including but not limited to information related to mental health, substance abuse and HIV status.

Name:_____ Email: _____ Relation:_____

EMERGENCY CONTACT INFORMATION

In the event we are unable to reach you to discuss important test results, or should there be a medical emergency during one of your visits, Cornerstone Family Healthcare will contact the person you indicate below.

Name:_____ Relation: _____

Contact #: _____ Select Type: ☐ Cell ☐ Home ☐ Work

Please note that the person you designated above does not have the right to your (or your child's) protected health information. If you choose to designate this person as someone who we may discuss your (or your child's) information with, please complete the appropiate section above.

Assignment of Benefits: I authorize payment of insurance benefits to Cornerstone Family Healthcare for medical, dental and/or radiology services provided to me. I authorize the release of medical or other information necessary to determine benefits coverage and eligibility. I understand that I am financially responsible for charges not covered by my insurance. It is my responsibility to notify Cornerstone Family Healthcare of any changes to my healthcare coverage.

Patient Initials: _____

Notice of Privacy Practices & HIPAA Acknowledgement: Cornerstone Family Healthcare is commited to protecting your Personal Health Information (PHI) and stay in compliance with federal and state laws such as HIPAA. I have received a copy of the Notice of Privacy Practices and understand how my PHI may be used, as well as my rights and Cornerstone Family Healthcare rights regarding PHI.

Patient Initials: _____

Consent to photograph for Electronic Health Record: I give consent to Cornerstone Family Healthcare to take my photographto be stored in my electronic health record. This photograph with be used to indentify me and help protect against identity theft.

Patient Initials: _____

Patient Bill of Rights and Patient Rights & Responsilbilities: I have received the Patient Bill of Rights & Responsibilities document.

General BOR: __X___ Mental Health Services BOR: _____ Patient Initials: _____

Advanced Directives: I have received the information on Advanced Directives. I understand that in order for my Advanced Directives to be honored, I must complete and submit a Health Care Proxyand/or Living Will form that has been provided to me.

General Advance Directives: _X__ Mental Health Services Advanced Directives: _____ Patient Initials: _____

Consent for TeleHealth/TelePsychiatry

I understand that telehealth/telepsychiatry is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider.

I understand that the laws that protect the privacy and the confidentiality of patient medical information also apply to telehealth services which may include general medicine and behavioral health. As always, my insurance carrier will have access to medical records for quality review/audits.

I understand that I will be responsible for any copayments or coinsurance that may apply to my telehealth visit.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment. I may also revoke my consent orally or in writing at any time by contacting Cornerstone Family Health Care.

TELEHEALTH/TELEPSYCHIATRY: I have been given information regarding the use of Telehealth/Telepsychiatry and consent to participate in services utilizing this technology. If I am under the age of 18, such information was shared with, and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in telepsychiatry services, in which case evaluations will be conducted in-person by appropriate clinicians. I understand that telepsychiatry services may reduce any delays in services, need to travel or other risks associated with not having the services provided by telepsychiatry/telehealth services. Furthermore, I am made aware that each telepsychiatry/telehealth session shall not be recorded without my consent. I agree to participate in telepsychiatry/telehealth services.

Signature: _____ **Date:** _____

General Consent for Treatment

1. I am asking for general medical care and treatment at Cornerstone Family Healthcare and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine dental and medical care. I understand that these services will be provided to me by physicians, dentist, nurse practitioner, midwives, physician assistant and other health care providers, some of whom may be in training. I have not been given any guarantees as to the results of the services I will receive.
2. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.
3. I understand that my agreement to accept these services is called a "General Consent for treatment" and that it includes any routine procedures(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking x-rays, use of local anesthesia and other non-invasive procedures.
4. E-Prescribing is defined by a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that must be included in an E- Prescribe program.

These include:

- Formulary and benefit transactions
  Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions
  Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification
  Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Cornerstone Family Healthcare can request and use your medical history from other healthcare providers, third party pharmacy benefit payors, pharmacy networks, and/or from health information exchanges, for treatment purposes.

Signature: _____ **Date:** _____

I certify that the above information is true and correct to the best of my ability.

Name of person completing this form: **(Print)** _____

Signature_____**Date:** _____

Relationship to patient: ☐ **Self** ☐ **Parent** ☐ **Legal-Guardian** ☐ **Other:**

Witness:
Employee Name & Title:_____

Employee Signature: _____ **Date:** _____
Form received by external source (please indicate the location site i.e., nursing home):
_____