Cornerstone Medical Associates (CMA)

NAME: First_____Middle_____Last_____
Suffix_____
Social Security # _____Date of Birth _____ Gender: ☐Female ☐Male
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Street: _____
Apt/Suite _____
City: _____ State _____Zip Code _____

Response to this section is optional, but requested by Insurance Companies
____Patient/Representative refused to answer

Race: ___ American Indian or Alaskan Native ____Caucasian ___ Hispanic ___ Black or African American ___Asian ___Native Hawaiian or Other Pacific Islander ___Other
Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino
Language: ___English ___Spanish ___Korean ___ Japanese ___Laotian ___Indian ___Russian ___Other

Contact Information
Home Phone: _____ Cell: _____
Work:_____Ext.:_____
Email_____

Preference for appointment reminders: ☐ Home ☐Cell ☐Work ☐Text Msg (cell only) ☐Voice Message

Preferred time to receive voice message: _____Morning (8-12) _____Afternoon (12-5) _____Evening (6-8)
Can we leave x-ray and/or laboratory information on your Cell Phone or Home Phone? ___Yes ___No

Release of Information Authorization & HIPAA Notification
I hereby authorize CMA health care providers, their agents or affiliates, by signing this form, to release such patient-identifiable medical information (which may include drug/alcohol abuse, HIV status or psychiatric treatment) to my insurance companies and managed care organizations, TennCare, Medicaid, and other federal programs as necessary to perform administrative functions and to bill for and verify my treatment.

I Authorize CMA, its employee my physicians and other providers to release to the Social Security Administration or its intermediaries any information needed for processing any Medicare claim.
I authorize disclosures and communications, including general medical condition, plan, treatment or payment with: ___Pharmacies ___Referring Specialists ___Hospital Staff and ____ Family members listed:

1._____
Name Phone Number Relationship
2._____
Name Phone Number Relationship
3._____
Name Phone Number Relationship

EmergencyContact:_____
Name Phone Number Relationship

I authorize the above named person to be my emergency contact. In the event of a medical emergency situation, this person may receive my PHI (protected Health Information) related to the emergency for which they were contacted.
I have received a copy of my rights under HIPAA (Health Information Portability and Accountability Act) or have been given access to a copy of such. **(Copies of the privacy notice are available at the front desk. Please feel free request one.)** ____Initial

I may revoke this authorization at any time by notifying CMA in writing. If I do not revoke it earlier, my authorization will expire twelve months after the date I signed this form.
_____Initial

Assignment of Benefits
I hereby authorize and request all insurance carriers, HMOs or managed care organizations with which I have coverage, including, if applicable, Medicare and Medicaid, to pay directly to CMA any and all benefits due under the terms of my policy for services provided by CMA, including any settlements or judgments for such services. If my health insurance will not allow direct payment to CMA, I agree to immediately forward to CMA all health insurance payments I receive for my care and treatment at CMA. Due to our office policy, we do not file tertiary insurance. ____Initial

Advance Directive / Living Will/ POA
I have an advance directive such as a living will or durable power of attorney for my healthcare in the event I am unable to make my own medical decisions? ____Yes ____No. If yes, please provide copy for your chart.

Agreement to Pay

I acknowledge and agree that I am financially responsible and will pay for any deductible or co-payment for all services and treatment provided to me, including any amount not paid by my insurance plan, to the extent legally permissible, at time of service.

If a delinquent account is referred for collection, I agree to pay reasonable attorney's fees, court cost and/or collection agency fees associated with the collection process.

I have read this agreement or have had it read to me.

I acknowledge that the information I have provided is accurate. By voluntarily signing this agreement, I accept and agree to comply with its terms.

_____	_____	_____
Name of Patient (Print)	Signature of Patient	Date