2025

CORNERSTONE PRIMARY HEALTHCARE

117 Maple Row Blvd. Hendersonville, TN 37075
Phone (615)824-1616 Fax (615) 824-1622

Patient Last Name:	Patient First Name:	M.I.:	Maiden Name:	Date of Birth:
Social Security#:	Gender: Male / Female	Spouse/Parent Name:		Spouse/Parent Phone #:
Home Phone #:	Cell Phone#	Employer/School:		Work Phone#:
Home Street Address:	Apt	City	State:	Zip Code:
Marital Status:	**Race**:	**Language Preference**:	Email Address:	
Preferred Pharmacy / Location	Pharmacy Phone:	**Do you have a living will?**	**Do you have a Power of Attorney? Yes No (If yes, we require a copy of the document for our records.)**	

****Please review and initial beside each policy item****

___ I certify that the information I have provided is true to the best of my knowledge. I understand it is my responsibility to keep my insurance, phone number and address current and will contact Cornerstone Primary Healthcare with updates as they occur.

___ I authorize my insurance benefits to be paid directly to the provider. I understand I am responsible for knowing my insurance plan and coverage/exclusions. **Cornerstone Primary Healthcare is NOT contracted with MEDICAID or TENNCARE.** CPH may also be excluded from other insurance plans.

___Some Insurance Companies allow us to do a Physical (Wellness) and sick/refill/problem visit on the same day but, we are required to submit a separate office visit charge**. A Sick/Refill/Problem Visit is NOT covered under the Wellness Benefit and copays/deductibles will apply**.

___ I understand that I am financially responsible for any balance/Copay that was NOT covered by my insurance and assigned to me.

___ I am aware that Cornerstone Primary Healthcare will collect all co-pays/deductibles and balances prior to being seen. I understand if I cannot pay my copay/balance, I will be asked to reschedule my appointment. I understand all monies are due regardless of if a statement/notification was received. I understand a copy of the receipt/statement will be provided if requested.

___ I am aware that if I do not have proof of valid insurance that full payment is expected at the time of service.

___ I understand that a $45.00 fee will be charged each time medical forms are completed (excluding Biometric Forms).

___ I am aware that if I fail to show for an appointment a $45.00 fee per missed appointment will be charged to my account. A 24-hour notice must be given to reschedule or cancel my appointment, or I will be charged a $45.00 fee.

___ I understand that the automated appointment reminders are a courtesy and not receiving one does not excuse me from missing my appointment.

___ Two missed appointments or two appointments cancelled/rescheduled same day, may result in my dismissal from the practice.

___ One statement will be mailed to address on file. TEXT notifications will follow for all past due accounts. A 5% late fee will be charged to any balance remaining after 30 days.

___ Ignoring my bill or not having current contact information on file will cause a delinquency in my account therefore resulting in aggressive collection done by a third party. The collection fees (30%) incurred will be an additional charge for which I am responsible.

___ I understand that If I transfer care or I am dismissed for any reason, I will no longer be a patient of CPH. I understand once dismissed/transferred from practice; I will not be allowed to schedule any appointments with my provider and all future appointments will be cancelled.

___ It is the Policy of Cornerstone Primary Healthcare to contact patients by phone and if needed leave a voice mail. The voice mail may contain information concerning appointments, test results, referral appointments and outstanding balances. If no VM is set up or if full, a text message will be sent instead. Leaving a message on my phone/cell phone and receiving text messages is acceptable to me.

_____ _____

Patient/ Guardian Signature **Date**

Patient Portal Policy (Updated 01/01/2025)

In 2021, our practice moved to the use of a secure patient portal to provide a more efficient means of communicating lab results with our patients. This portal provides immediate access to your lab results once they have been reviewed by your provider. It also provides us a way to give you written directions on any medication changes (prescription or over the counter) that you need based on those results. After providing us with your email address, our charting system will send you an email with a link and temporary password. Just click on the link and put in the password to access your portal. Once in the portal, just change your password to something only you would know. When your provider has signed off the labs you will receive an email stating you have a lab message. Just sign into your portal and review your results and provider comments. We will no longer be printing off copies of lab results in the office. Should you need a personal copy of them, you will need to log in to the portal and print them to your own device. However, we will be glad to fax a copy to a specialist if that is needed. PATIENTS WILL NO LONGER BE CALLED WITH NORMAL RESULTS. If you choose NOT to use the patient portal, an appointment will be required to discuss results with your provider. Thank you for understanding.

_____ _____ _____

Patient /Guardian Signature Date Email (for portal notifications)

Patient Name:_____ Date of Birth:_____

Please list your medical history and any chronic illnesses:

_____

_____

Please list any Surgeries/Procedures and the year performed

_____

_____

Family Medical History:

Maternal History/Family Relation

_____

_____

Fraternal History/Family Relation

_____

_____

Drug/Food/Medication Allergies and Reactions

_____

_____

Current Medications with Dosage and Frequency

_____

_____

_____

Over the Counter Medications/Vitamins/Herbs

_____

_____

- Do you drink caffeine? Yes No If yes, how much per day?
- Do you smoke? Yes No How many a day? When did you quit?
- Do you use recreational drugs? Yes No If yes, how much per week?
- Do you drink alcohol? Yes No If yes, how much per week?
- We like to acknowledge our referral sources so please let us know how you heard about our office: Current Patient:_____ Insurance List Newspaper Ad Our Website Other:_____

Consent to Treat

I hereby authorize Cornerstone Primary Healthcare and any of its Nurse Practitioners and/or staff to treat my medical conditions. The risk benefits and alternatives will be explained at the time of service. I have the right to question and/or refuse treatment. I hereby release Cornerstone Primary Healthcare and/or staff from any liability.

_____ _____

Patient/ Guardian Signature Date

YOUR MEDICAL & FINANCIAL RECORDS

SELF PAY: _____ Yes _____No

If NO, please complete Insurance Information.

Insurance Information: MUST BE FILLED OUT

Primary Insurance Company:	Subscriber Name: Relationship to Patient: Parent/Step-Parent/Spouse	Subscriber Address:	Subscriber Date of Birth:
ID Number (Policy Number):	Group Number:	Insurance Company Phone#:	Subscriber Social Security #
Secondary Insurance Company:	Subscriber Name: Relationship to Patient: Parent/Step-Parent/Spouse	Subscriber Address:	Subscriber Date of Birth:
ID Number (Policy Number):	Group Number:	Insurance Company Phone#:	Subscriber Social Security #

By signing this information, I understand this will allow my insurance company to be billed:

Patient/Guardian Signature_____ DOB_____ Date_____

TennCare or Medicaid

I understand that Cornerstone Primary Healthcare does not take TennCare or any Medicaid policies. In signing this, I attest I do not have TennCare or Medicaid. I also understand if at anytime I acquire one of these policies I must disclose this information to Cornerstone Primary Healthcare before my next office visit. I understand if I have coverage under either plan and do not disclose this information, my actions will be considered fraudulent, and I will be discharged from the practice.

Patient/Guardian Signature_____ DOB_____ Date_____

Patient Name: _____ DOB: _____

Patient Record of Disclosures

In General, the HIPAA privacy rule gives individuals the right to request a restriction for uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and request for PHI to the minimum necessary to accomplish the intended use. These provisions do not apply to uses or disclosure made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosers. Information provided below, if completed properly, will constitute an adequate record.

Authorization to Release Protected Health Information

By Signing Below, I authorize my medical providers to discuss my medical care, health history, diagnosis and treatment options with the following authorized person(s):

Name: _____ DOB: _____ Phone Number: _____ Relationship:_____

Name: _____ DOB: _____ Phone Number: _____Relationship:_____

DO NOT RELEASE ANY INFORMATION to the following person(s)

Name: _____ DOB: _____ Phone Number: _____

Name: _____ DOB: _____ Phone Number: _____

Patient/Guardian's Signature: _____ Date:_____

****We will not respond to Medical questions/information postings on Social Media (Facebook or Twitter). Please contact the office for any questions or issues that you may have. Any text or e-mails to our personal phones are not guaranteed to be secure format. If you contact an employee via their personal phone, you will be asked to contact the office.*

Copies of the Health Insurance Portability and Accountability Act (HIPAA) and our policy on Controlled Drugs are available at the front desk for you to review at any time. If you have any questions, please let the front desk know.

117 Maple Row Blvd.,
Hendersonville, TN 37075
Phone (615)824-1616 Fax (615) 824-1622

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the following healthcare provider(s) and its physicians, employees and agents to release or disclose to Cornerstone Primary Healthcare all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection.

Provider	**Address**	**Phone Number**
_____		
_____		

I further authorize you to provide to and discuss with Cornerstone Primary Healthcare any confidential information with respect to my medical condition or treatment, either formally or informally.

Release Records to: **Cornerstone Primary Healthcare**
117 Maple Row Blvd.,
Hendersonville, TN 37075

Purpose of Disclosure: For use in continued medical care

Patient's Name: _____ SSN: _____ Date of Birth: _____

Records to release:
_____ All Records
_____ All Laboratory Results
_____ Records from _____ to _____
_____ The following specified records: _____

I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the above-named healthcare provider(s) before the healthcare provider(s) received my revocation. Should I desire to revoke this Authorization, I must send written notice to the healthcare provider(s).

I understand that I am not required to sign this Authorization. The above-named healthcare provider(s) will not condition treatment, payment or eligibility on whether I provide this Authorization.

I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the above-named healthcare provider(s) ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law.

I further understand and acknowledge that I am responsible for all costs associated with the provision of the information described herein to Cornerstone Primary Healthcare.

Patient/Guardian's Signature: _____ Date: _____

Relationship to Patient: _____

THIS AUTHORIZATION WILL EXPIRE 5 YEARS FROM DATE ABOVE. A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.