CORNERSTONE
PRIMARY HEALTHCARE

2025

Patient Last Name:	Patient First Name:	M.I.:	Maiden Name:	Date of Birth:

Social Security#:	Marital Status	Spouse/Parent Name:	Spouse/Parent Phone #:

Home Phone #:	Cell Phone#	Employer/School:	Work Phone#:

Home Street Address:	Apt#	City	State	Zip:

Preferred Pharmacy:	Pharmacy Phone:	Pharmacy Location:	Email:

Required Insurance Information: All Information Must Be Provided

Primary Insurance Company:	Subscriber Name: Relationship to Patient:	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:	Subscriber Address:	Subscriber Date of Birth:
ID Number (Policy Number):	Group Number:	Insurance Company Phone#:	Subscriber Social Security #

****REQUIRED: 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.

___I have reviewed the CPH Patient Portal Policy. I understand that my lab/Imaging results will be uploaded to the portal for my review. I understand that **printed copies or emailed results will no longer be provided**. IF I choose not to use the portal, I understand that an appointment will be required to discuss these results.

Email for the Patient Portal _____

(EMAIL Address Provided Can Not Be Used/Shared with Another Patient)

_____ _____

Patient/ Guardian Signature **Date**