cornerstone
WELLNESS CENTER

First:_____ **Last:**_____

Date of Birth:_____/_____/_____ **Age:**_____ **Sex: Male/Female (circle one)**

Address:_____

City:_____ **State:**_____ **Zip:**_____

Cell:(_____**)**_____**-**_____ **Email:**_____

SSN:_____**-**_____**-**_____ **Occupation:**_____

Emergency Contact:_____ **Cell:(**_____**)**_____**-**_____

Who may we thank for your referral?_____

I have read the above information and certify that it is true and correct to the best of my knowledge and hereby authorize Cornerstone Physical Medicine, LLC. and its affiliates to do what is necessary, in accordance with state statutes, for the care and management of the complaint noted.

Patient Signature:_____ **Date:**_____/_____/_____

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Patient Name: _____ Date: _____

Reason For Visit: _____

_____

Are Your Under Physician Care: Y / N If Yes, Physician Name & Phone: _____

Please List Current Medications/Supplements: _____

_____

_____

Allergies (List): _____

Surgeries/Traumatic Injuries: _____

_____

Family Medical History

☐ Allergies	☐ Depression	☐ High Blood Pressure	☐ Asthma	☐ Stroke
☐ Arthritis	☐ Heart Disease	☐ Respiratory Disease	☐ Alcoholism	☐ Diabetes
☐ Cancer	☐ Seizure			

Habits / Excessive Use

☐ Alcohol	☐ Coffee	☐ Food	☐ Tea	☐ Exercise
☐ Artificial Sweetener	☐ Cola	☐ Salt	☐ Other	☐ Sugar
☐ Chocolate	☐ Drugs	☐ Sex	☐ Cigarettes	

General (please check all that apply in last 3 months)

☐ Poor Appetite	☐ Fevers	☐ Desire Cold Drinks	☐ Low Energy	☐ Vertigo
☐ Change In Appetite	☐ Chills	☐ Insomnia	☐ Body Heaviness	☐ Dizzy
☐ Large Appetite	☐ Sweating	☐ Easy To Fall Asleep	☐ Sleep Apnea	☐ Bleed or Bruise Easy
☐ Cravings	☐ Night Sweats	☐ Difficult To Fall Asleep	☐ Dream Disturbed Sleep	☐ Headache
☐ Weight Gain	☐ Sweat Easily	☐ Desire Hot Drinks	☐ Fatigue	☐ Hot Flash
☐ Back Pain	☐ Joint Pain	☐ Neck Pain	☐ Shoulder Pain	☐ Irritability
☐ Weight Loss	☐ Nausea/Vomitting	☐ Gas/Belching	☐ Diarrhea/Constipation	

Your Past Medical History

☐ AIDs/HIV	☐ Candia	☐ Herpes	☐ Pneumonia	☐ Stroke
☐ Alcoholism	☐ CFS	☐ Hernia	☐ Prostate Problems	☐ Substance Abuse
☐ Allergies	☐ Colitis	☐ Herniated Disc	☐ Osteoporosis	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatoid Arthritis	☐ Tuberculosis
☐ Arthritis	☐ Epilepsy	☐ High Cholesterol	☐ STD	☐ Ulcers
☐ Auto Immune Disease	☐ Gout	☐ Kidney Disease	☐ Mononucleosis	☐ Whooping Cough
☐ Bleeding Disorder	☐ Gall Stones	☐ Liver Disease	☐ Low Blood Pressure	☐ Migraines
☐ Breast Cysts	☐ Headaches	☐ Heart Disease	☐ MS	☐ Hepatitis
☐ Acid Regurgitation	☐ Anxiety	☐ Depression	☐ Infertility	☐ Bladder Issues
☐ Impotency	☐ Irritable Bowel	☐ Decreased Libido	☐ Bi Polar	☐ Cancer

Gynecology

☐ Age Menses Began	☐ Endometriosis	☐ Spotting Between Periods	☐ Date of Last PAP _____	☐ # Pregnancies _____
☐ Length of Cycle	☐ Pelvic Pain	☐ Vaginal Discharge / Odor	☐ Date of Last Period _____	☐ # Live Births _____
☐ Duration of Flow	☐ Fibroids	☐ Flow Thick/Thin	☐ Color _____	☐ # Miscarriages _____
☐ Irregular Period	☐ Infertility	☐ Amount Scanty / Heavy	☐ Clots	☐ # Premature Births _____
☐ Painful Period	☐ Ovarian Cysts	☐ PMS	☐ Decreased Libido	☐ # Abortions _____

Other

☐ _____

Office Policy, Procedures & Disclosures

Cancellation Policy:

There is a $35 charge for missed appointments without a 24-hour advance notice for any appointment with the Chiropractor, Physical Therapist, Acupuncturist and/or the Massage Therapist. For those patients who have purchased a massage package, one massage will be used from the package if the appointment is not cancelled 24 hours before the scheduled massage.

Consent to care

As a patient with Cornerstone Wellness Center, you have the right to know the types of treatment we could possibly use and any complications/side-effects to such treatment. The procedures performed in our clinic are usually beneficial, however, unexpected issues may arise. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not provide specific treatments if he/she is aware that such care may be contraindicated. Patients are responsible for informing doctors about any conditions, diseases, illnesses, etc. Patients agree to settle any claim or dispute against or with our clinic or personnel, when related to the prescribed care or otherwise, by binding arbitration under current malpractice terms which can be obtained by written request. Cornerstone Wellness Center may refer you out to other ancillary services that Cornerstone Wellness Center may have ownership to. Patients hereby allow treatment to be rendered to themselves by all Cornerstone Wellness Center, physicians or staff.

Financial Policy

The patient is ultimately responsible for full payment of their treatment and care whether or not paid by insurance. Your insurance Policy is a contract between you and your insurance. As a courtesy, we check your insurance for benefits. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payments of co-pays, co-insurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients authorize the release of healthcare information and records to all insurance companies. Patients are responsible for contacting their insurance carrier for explanation of any services not covered. Payment is due at the time of service, and for your convenience, we accept cash, and most major credit and debit cards at our office. Any prepaid packages are refundable if not used within 90 days of payment. After 90 days, the unused portion will revert to a credit which must be used within 2 years of original payment. Any credits not used within the two years will be forfeited. Any insurance checks sent directly to you or the insurance policy holder for services rendered with Cornerstone Wellness Center must be brought into our clinic.

Collections

If a patient's account is not paid in full within 90 days, it will be considered delinquent. No additional appointments will be made for patients with delinquent accounts until they are current. Delinquent accounts will be turned over to a licensed collection agency; there will be a collection fee equal to 30% of our outstanding balance at the time the account is placed with the collection agency.

Miscellaneous:

There is a $35 charge for forms completion by our Providers, including but not limited to disability and FMLA forms.

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I have read, understand, and agree to the provisions of this Patient Financial Responsibility and Disclosure Form:
Please sign/date below:

Printed Patient Name: _____ Date: _____

Signature of Patient: _____Witness:_____

Health Care Information Authorization

At times our office may need to contact you with appointment information about treatment or other health related information. By signing below, you are giving **Cornerstone Wellness Center authorization** to contact you by the following:

(Please draw a single line through any methods you REFUSE and initial)

- I may be contacted by home, work, or cellphone.
- Messages may be left on my home, work, or cell voicemail OR to any individuals answering my phone at home or work.
- Also I may be contacted by postal mail or e-mail to send personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders.
- With my permission, my name and or photograph may be used for office events, bulletin boards, newsletters or patient testimonials.

You have the right to revoke this AUTHORIZATION, in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the privacy Official of **Cornerstone Wellness Center.** The written notice must contain the following information:

- Your name, social security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Officials.

This AUTHORIZATION is requested by **Cornerstone Wellness Center** for its own use/ disclosure of protected health information. (Minimum necessary standards apply.) You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION **Cornerstone Wellness Center** will not refuse to provide treatment. You have the right to inspect or copy the protected health information to be used/disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU **

Personal representatives (family members, attorneys, etc. I hereby authorize **Cornerstone Wellness Center** and its employee's to discuss, send and/ or receive medical information to/with the following individuals:

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

We like to co-manage your case with your Primary Care Physician; do you authorize us to send notes or records to them? Yes No

If yes, please provide us the following information: Primary Care Doctor_____Office Phone#_____

My signature below indicates that I have read and agree to the above authorization and I acknowledge that I have read a copy of **Cornerstone Wellness Center** Notice of Privacy Practices.

Patient Name (print):_____ Patient Representative (print):_____

Patient Signature:_____ Patient Representative Signature:_____

Date:_____/_____/_____