Please answer all questions. This form voids any previous info on file.

Name: (First, Middle, and Last)_____

Maiden Name:_____ Sex: M____F_____ SS#_____

Marital Status M__S__W__D__ Sep.__ Birthdate:_____

Race_____ Primary Doctor: _____

Mailing Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____ Preferred Contact: Home Cell Portal

Preferred Contact Method: Patient Portal__ Phone__ Email Address:_____

Do you have an answering machine where we may leave messages? Y__N__

Name of Parent or Guardian and Birthdate (if minor):_____

Preferred Pharmacy:_____ City, State of Pharmacy: _____

Is the child living with both parents? Y__ N__ If not, who has custody?_____

If living with someone other than parent, Name and Relationship:_____

Emergency Contact Name & Phone:_____Relationship: _____

Patient's Employer:_____ Work Phone:_____

Insurance: _____ Policy Holder:_____

Policy Holder Date of Birth: _____

Payment is due at the time of service including copay, deductible, co-insurance etc. unless other arrangements have been made.

**A COPY OF YOUR INSURANCE/MEDICAL CARD AND DRIVERS LICENSE ARE REQUIRED AT EACH OFFICE VISIT.**

I hereby give my consent for treatment and authorize my insurance benefits to be paid directly to Cornerstone Family Medicine realizing that I am responsible for paying for services regardless of insurance. I hereby authorize the release of pertinent medical information to the insurance carriers and collection agency if needed. I also understand that I will pay at the time of service in the absence of insurance, unless prior arrangements have been made. I consent to medication reconciliation as needed for my office visits.
**Date**:_____ **Signature**_____

This section is optional, but if not completed we cannot speak to anyone including spouse, parent, etc. I give my permission for Cornerstone Family Medicine to speak with (name and phone number) _____, regarding my medical testing, lab work, x-rays, etc. This form is valid until a note is signed by the patient stating that they no longer request this information to be given to this individual.
**Date**:_____**Signature**:_____

OVER

**Collections Policy**: After three statements have been mailed to patient without receiving any payment you will be notified by mail and sent to our outside collection agency. In order to return as a patient, I agree to pay a 30% fee along with the outstanding balance before being scheduled.

**No Show Policy**: We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know 24 hours in advance. A NO SHOW is when a patient fails to keep a scheduled appointment. A NO SHOW will generate a $35 fee and three no shows may require that you seek your medical care elsewhere. In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances. If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any delay may require the visit to be rescheduled. Keep in mind you should arrive 15 minutes before any appointment.

**Date**:_____**Signature**:_____

CRISP & Maryland Immunization Information System (Immunet): We participate in Immunet (containing the names and immunization history of people who have received vaccinations in Maryland). **If you do not wish to participate in this please ask our receptionist for an opt-out form for Immunet.**

I have been advised of the policies listed above.
I have received the notice of privacy practices and have been given the opportunity to review it.

**Signature:**_____ **Date**:_____

Notice of Privacy Practices Acknowledgement Page: We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org.

**Signature:**_____ **Date:**_____