Patient Intake Form

Please Print or Type

Cornerstone Psychiatric Services, Inc.
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1790 E Venice Ave. Ste. 204, Venice, FL 34292
Phone: (941) 488-8884 Fax: (941) 488-5554

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **Middle Name:**_____
Suffix: JR SR III IV or _____ **Preferred Name:**_____ **Date of Birth:**____/____/____

Gender: □ Male □ Female **Marital Status:** □ Divorced □ Married □ Separated □ Single □ Widowed

SSN:_____-_____-_____ **Spouse Name and Contact#:**_____

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Email*:_____ **Home#:** (_____)_____-_____ **Mobile#:**(_____)_____-_____
*Your email will be used to invite you to Patient Portal access.

Work#:(_____)_____-_____ **Other#:**(_____)_____-_____

Race: □ White – Non Hispanic □ Black – Non Hispanic □ American Indian/Alaskan Native
□ Pacific Islander □ Asian □ Other:_____

Ethnicity: □Hispanic □ Non-Hispanic □ Unknown **Language:** □ English □ Other:_____

COMMUNICATING WITH YOU

How do you prefer to receive appointment reminder notifications?

□ Email Voice Call to: □ Home □ Mobile □ Work □ Other □ SMS/Text to Mobile/Cell

You agree and acknowledge that email, calls, texts, voicemail and any form of messaging to your home, mobile, work or other contact will pertain to information regarding things like appointments, patient portal, test results, medication side effects and prescriptions. If you wish to extend communication regarding your specific medical treatment and share of information with others, we ask that you sign a Release of Information form. If this information should at any time need to be modified, please complete a new Patient Demographic Form and/or ROI form with your requested change(s). If you wish to opt-out of any form of communication, please specify here_____.

If you give permission for us to communicate with anyone else, please complete the list below:

Name and relationship	Contact #	Options (please check options)
Name: Relationship:	( ) _____ - _____ □ Check this box if this is a cell phone number	□ Billing Information □ Appointment Information □ Medical/Health Information □ All of them
Name: Relationship:	( ) _____ - _____ □ Check this box if this is a cell phone number	□ Billing Information □ Appointment Information □ Medical/Health Information □ All of them

REFERRAL and PCP INFORMATION

If you were referred to our practice, please provide name and phone number:
Referred by:_____ Referred phone#:_____
Please provide the name and phone # of your Primary Care Provider:
Primary Care Provider (PCP):_____ PCP phone#:_____

LAB AND PHARMACY CHOICES

Tell us which lab company you normally use and your local pharmacy and mail order pharmacy that you use to fill your prescriptions:

Lab: □ Quest Diagnostics □ Labcorp □ Other:_____

Local Pharmacy: □ Costco □ CVS □ Publix □ Sam's Club □ Target □ Walgreens □ WinnDixie □ Other:_____
Local pharmacy Store#, Address or phone#:_____

Mail Order Pharmacy: □ CVS Caremark □ Express Scripts □ OptumRx □ PrimeMail □ Other:_____

PATIENT STUDENT / EMPLOYMENT DETAILS

Student Status: □ Full-time □ Part-time □ Not a student **School/College Name:**_____

Occupation:_____

Employment Status: □ Full-time □ Part-time □ Not Employed □ Self Employed □ On active military duty □ Unknown

Employer Name: _____ **Employer Work#:** (_____)_____-_____

Employer Address:_____ **City, State and Zip:**_____

EMERGENCY CONTACT

Contact Name: _____ **Relationship:**_____

Phone#: (_____)_____-_____ **Mobile#:**(_____)_____-_____

INSURANCE / FINANCIAL RESPONSIBILITY

Primary Payer: □ Self pay □ Aetna □ BCBS □ Cigna □ Golden Rule □ Magellan □ Medicare □ Tricare
□ United Healthcare/UBH □ Beacon Health Options (ValueOptions) □ Other:_____

Primary Insurance ID#:_____ **Group#**_____ **COPAY (if known):**_____

Subscriber's Full Name: □ Same as patient □ Other:_____

Subscriber's Birthdate:_____ **Subscriber's SS#:**_____

----------Secondary Insurance Payer (complete only if you have a secondary payer)----------

Important Notice: We do not accept Florida Medicaid, out-of-state Medicaid plans or any Medicaid HMO plans

Secondary Payer (if any): □ Aetna □ AARP by UHC □ Bankers Life/Colonial Penn □ BCBS □ Cigna □ Golden Rule □ Magellan
□ Medicare 2ndry □ Tricare □ United Healthcare/UBH □ BeaconHealth Options □ Other:_____

2nd Insurance ID#:_____ **Group#**_____ **COPAY (if known):**_____

INSURANCE ASSIGNMENT AND SELF PAY AGREEMENT
AUTHORIZATION TO RELEASE

I certify that I have insurance coverage with the primary insurance company, if applicable; and the secondary insurance payer, if applicable, listed above. I assign directly to "Cornerstone" Psychiatric Services, Inc. (including David Donahue, D.O., David Fawks, ARNP and Nina Kirchgessner, ARNP, Gerald Horton, LCSW), all insurance payments, if any, otherwise payable to me for services rendered. I understand I am financially responsible for deductible, co-payments, co-insurance amounts, non-covered charges, and any and all balances not covered under a contractual agreement between "Cornerstone" and my insurance or other third party payer. I authorize the use of my signature for all insurance submissions. I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to "Cornerstone" for any services furnished to me by that provider.

If Self Pay, I understand it is my responsibility to pay for services rendered at time of visit.

I understand and agree that "Cornerstone" may use my health care information to the above named insurance payer(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that if an authorization is needed from my insurance plan, it is my responsibility to obtain such authorization and provide this to "Cornerstone".

***Signature* of Patient, Parent or Personal Representative:**_____

Print name of Patient, Parent or Personal Representative:_____

Relationship of Patient: □ Self □ Parent □ POA/Caregiver **Date:**_____

PATIENT CONSENT FOR EVALUATION OR TREATMENT
CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
CONSENT FOR OFFICE POLICIES and PATIENT PORTAL POLICIES AND PROCEDURES

Medical / Psychiatric care and treatment at Cornerstone Psychiatric Services, Inc. may be provided by Physicians, Advanced Registered Nurse Practitioners (ARNP), Licensed Clinical Social Workers (LCSW) or other State of Florida recognized behavioral health practitioners. I understand that clinicians David Fawks and Nina Kirchgessner are ARNP's. I hereby authorize Cornerstone Psychiatric Services, Inc. to evaluate, diagnose, and render appropriate treatment to the patient designated below. This consent is knowingly and freely given. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Center of Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

I hereby give my consent for **Cornerstone Psychiatric Services and their Business Associate's** (such as, but not limited to, medical billing company, EHR vendor, collection agency, automated appointment reminder vendor, dictation service, and electronic prescription vendor) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). You can ask for a copy or download a copy from our website www.cornerstonepsychiatric.com of the Notice of Privacy Practices provided by **Cornerstone Psychiatric Services** which describes such uses and disclosure in detail.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Cornerstone Psychiatric Services** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Privacy Officer at 1790 E Venice Ave. Ste 204, Venice, FL 34292**. You can also pick up a copy in our office.

With this consent, **Cornerstone Psychiatric Services** may communicate to me in reference to any items that assist the practice in carrying out TPO, such as, but not limited to, appointment reminders, billing statements, insurance issues and any messages pertaining to my clinical care, including laboratory test results, among others by use of phone calls to my home, mobile or other alternative location and speak or leave a message; SMS/Text message, Email, postal delivery and/or by the Patient Portal.

It is further understood that all information given by the patient or family member to a treating clinician is ***confidential*** and will not be released, except under special circumstances, without patient consent or consent of legal guardian as described in details in the Notice of Privacy Practices. You can authorize us to release information relating to your treatment to another person, provider or company by signing a Release of Information (ROI) form provided by our office.

By signing this form, I am consenting to allow Cornerstone Psychiatric Services to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cornerstone Psychiatric Services may decline to provide treatment to me.

I understand and agree with all the preceding information unless otherwise indicated in writing. I have received or been offered to review a copy of the following documents: Cornerstone "Welcome Letter", "Patient Rights and Responsibilities" , "Notice of Privacy Practices", "Office Policies", and "Patient Portal Policy and Procedures". I agree and accept the terms of all these documents. Copies of these documents are available at your request in our office or by downloading from our website, www.cornerstonepsychiatric.com.

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____

Print name of Patient, Parent, Guardian or Personal Representative

HEALTH SCREENING INFORMATION

The following information is provided by: □ Patient □ Parent □ Family member □ Other:_____

Advanced Directives:
□ None □ Do Not Resuscitate □ Durable Power of Attorney □ Living Will □ Healthcare Proxy

1. Chief Complaint: What is the reason for your visit?

□ Addiction
□ ADHD
□ Anger/Temper
□ Anxiety
□ Concentration is poor
□ Confusion
□ Depression
□ Energy level decreased
□ Grief
□ Guilt
□ Hallucinations
□ Helpless
□ Hopeless
□ Impulsivity
□ Irritability
□ Isolation
□ Mania
□ Medication Effects
□ Memory problem
□ Obsession
□ Panic Attacks
□ Paranoia
□ Phobia
□ Self-injury
□ Suicidal Thoughts
□ Tearfulness
□ Worthlessness
□ Other, please explain:

_____

_____

_____

2. Psychiatric History:

Have you ever been treated for Mental Health issues? □ YES □ NO

If YES, then answer the Treatment History tables below. If NO, then skip to next question on Stressors.

INPATIENT TREATMENT HISTORY IN HOSPITAL or PARTIAL HOSPITALIZATION:

Facility Name	Dates of Treatment	Reason or Explanation of this treatment

OUTPATIENT TREATMENT HISTORY:

Psychiatrist / ARNP / Therapist or Other Mental Health Provider Name	Dates of Treatment	Reason or Explanation of this treatment

STRESSORS:

□ Disability
□ Education Problems
□ Family
□ Financial Problems
□ Health Problems
□ Housing Problems
□ Limited Resources
□ Marriage
□ Peer/ Friendship
□ Support System
□ Work Issues
□ Other:_____

3. Substance Abuse History:

Have you ever been treated for alcohol or drug use or abuse? □ YES □ NO
If YES, then complete the Treatment History table below. If NO, continue to next question.

INPATIENT SUBSTANCE ABUSE TREATMENT HISTORY:

Facility Name	Dates of Treatment	Reason or Explanation of this treatment

Complete the table below regarding the following substances:

Substance	Have you ever tried before?	Age Started	Last used on this approx. date	Frequency of use	Lost Control?	Comments
Alcohol	□ Yes □ No					
Caffeine (coffee,tea,cola's)	□ Yes □ No					
Cigarettes, cigars or tobacco	□ Yes □ No					
Cocaine	□ Yes □ No					
Hallucinogens (LCD, mushrooms, Mescaline)	□ Yes □ No					
Heroin	□ Yes □ No					
IV Drug use	□ Yes □ No					
Marijuana	□ Yes □ No					
Pain Pills	□ Yes □ No					
Other:	□ Yes □ No					

Periods of Abstinence:_____

Have you experienced any of the following withdrawal symptoms and on what substance(s)?

Withdrawal Symptom	Have you experienced?	What Substance(s)?
Anxiety	□ Yes □ No	
D.T's (delirium tremens)	□ Yes □ No	
Seizures	□ Yes □ No	
Sweating	□ Yes □ No	
Tremors	□ Yes □ No	
Tachycardia	□ Yes □ No	
Other:	□ Yes □ No	

SMOKING STATUS:

□ Current every day smoker □ Former smoker □ Never smoker □ Unknown current smoker
□ Current some day smoker □ Current smoker □ Unknown if ever smoked

4. Medical History:

Please check beside any illness you have now or have had in the past.

□ Arthritis	□ Chronic Pain	□ High Blood Pressure	□ Stomach Problems
□ Blood Disorders	□ Diabetes	□ Liver Disease	□ Stroke
□ Bowel Problems	□ Glaucoma/Vision Problems	□ Lung Disease/Breathing Problems	□ Thyroid Disease
□ Cancer	□ Heart Attack	□ Migraines	□ Ulcer
□ Chest Pain	□ Hepatitis	□ Seizures / Epilepsy	

□ Other, please explain:_____

SURGICAL PROCEDURES:

Type of Procedure	Date Occurred

SERIOUS INJURIES OR ACCIDENTS:

Type of Injury/Accident	Date Occurred

ALLERGIES:

Food / Medication Allergy	Type of Reaction

PAST PSYCHIATRIC ONLY MEDICATIONS YOU HAVE TRIED AND ARE NO LONGER TAKING:

Past Psychiatric Medications you have tried	Dose	Frequency	Date Started	Date Stopped	Reason for Stopping

CURRENT MEDICATIONS: (If you have a current list, please print off and attach with this form)

Current Medications	Dose	Frequency	Last dose taken

Have you ever discontinued or altered the prescribed dose of your medication without the recommendation of your treating physician? □ YES □ NO

If YES, please explain:_____

FOR WOMEN ONLY:

Date of last menstrual period:_____.

Are you currently pregnant? □ YES □ NO Are you planning to get pregnant in the near future? □ YES □ NO

Birth control method:_____

5. Family History

Has anyone in your family ever been treated for any of the following? (please check all that apply and when appropriate indicate paternal or maternal.

Illness	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
ADHD								
Alzheimer's Disease								
Anxiety / Panic Attacks								
Bipolar Disorder								
Depression								
Heart Disease								
Schizophrenia								
Seizures								
Stroke								
Substance Abuse								
Suicide Attempts								

NUTRITIONAL ASSESSMENT: Height:_____ Current Weight:_____

Without wanting to, have you lost / gained more than 10 pounds within the last 6 months? □ YES □ NO

If YES, Amount Weight Lost:_____ Amount Weight Gained:_____

Sleep Patterns: Hours each night: _____ □ Awakens Frequently □ Difficulty returning to sleep □ Difficulty falling asleep

FUNCTIONAL ASSESSMENT:

Have you experienced a recent loss of independence in caring for yourself? □ YES □ No

If YES, please explain:_____

Comments—In your own words, please describe why you have sought services with us?

_____

_____

_____

_____

Any other additional information you care to share with us?

_____

_____

_____

_____

>>>Please bring this completed new patient paperwork with you at your first appointment or send to us before your first appointment. Also, remember to bring your photo ID and insurance cards, if applicable. Thank you.