

# Cornerstone Family Practice

Good health is the Cornerstone to a good life

## PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_  
Address: \_\_\_\_\_ Apt/Unit: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

## INSURANCE HOLDER INFORMATION (IF NOT THE SAME AS ABOVE)

Policyholder's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Apt/Unit: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Policyholder's relationship to Patient: \_\_\_\_\_ Employer Name: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company Name: \_\_\_\_\_ ID or Policy Number: \_\_\_\_\_  
Group or Account Number: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_ Co-pay: \_\_\_\_\_  
Secondary Insurance Company Name: \_\_\_\_\_ ID or Policy Number: \_\_\_\_\_  
Group or Account Number: \_\_\_\_\_

### Assignment of Benefits

I authorize payment of medical benefits to Cornerstone Family Practice P.C. for professional services rendered.

### Acknowledgement of Financial Responsibility

The above information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, and the cost of collections in the event it is not. I further understand that if payment becomes over 90 days past due Cornerstone Family Practice will begin collection activity.

### Release of Information

I authorize the release of any medical information necessary to process all present and future claims.

### No show/ Cancellation Policy

I acknowledge that I will be billed (not my insurance) for any no-show or cancellations not made within 24 hours of my appointment.

### Co-pay Policy

I acknowledge that I am responsible for paying my co-pay amount to Cornerstone Family Practice prior to any appointment. If I fail to comply, I acknowledge that I will be billed, (not my insurance) a \$10.00 fee.

### Notice of Privacy Practices

I acknowledge that I have been offered access to Cornerstone Family Practice's Notice of Privacy Practices via the posted form and/or a hard copy provided by the receptionist.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or parent if a minor)

**\*\*Please Fill Out This Form in its Entirety to Ensure Proper Handling of Your Account\*\***  
**\*\*Please provide your insurance card to the receptionist to copy\*\***