2121 Abbott Rd, Suite 101, Anchorage, Alaska

99507 Medical: (907) 522-7090 Fax 522-7095

Affiliate of Christian Health Associates

CORNERSTONE HEALTH

Medical ▪ Counseling ▪ Recovery

Patient Demographics Form

Last Name: _____ First Name: _____ Middle Name: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Sex: ____ Male ____Female

Email: _____ (this will be used to establish a patient portal account)

Phone # (Cell/home/work): _____ Phone # (Cell/home/work): _____

Preferred Local Pharmacy: _____ Preferred Mail Pharmacy: _____

Cornerstone Medical Clinic uses an electronic prescribing system which helps streamline your prescriptions to prevent prescribing errors

Insurance Information

Is your visit today due to an injury? ____Yes ____No If so, please provide the information below:

Motor Vehicle Accident: Claim #: _____ Adjuster name & Number: _____

Worker's Compensation: Claim #: _____ Adjuster name & Number: _____

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Emergency Contact

Name: _____ Relationship to Patient: _____

Phone: _____ Alternate Phone: _____

Would you like this contact to be your authorized HIPAA designee? ___Yes ___No (Access listed below)

Please select the option you would like the person named above to have access to: ____Medical ___Billing

Name: _____ Relationship to Patient: _____

Phone: _____ Alternate Phone: _____ _____

Would you like this contact to be your authorized HIPAA designee? ____Yes ____No (Access listed below)

Please select the option you would like the person named above to have access to: _____Medical ____Billing

PLEASE SEE OTHER SIDE

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The following is information we feel important to the mutual understanding between Cornerstone Medical Clinic (CMC) and our patients.

FINANCIAL DISCLOSURE

Payment is due at the time of services; payment includes any co-payment or deductible requirements set by your insurance company or total amount due for non-insured patients. Accounts with balances greater than 90 days may be referred to a collection agency and can incur additional fees, which may be added to the delinquent account.

CMC will submit your billing claims to your insurance company; it is your responsibility to furnish all insurance information correctly prior to treatment. We cannot quote or guarantee your benefits and feel that your role in managed care participation is to know your benefits and alert us of any non-covered services. Insurance balances greater than 90 days and all non-covered services will be billed to the patient. Please remember that your insurance policy is an agreement between a patient and their insurance company. Any co-payments required by an insurance company ***must*** be paid at the time of service.

Patient Consent

I _____, authorize CMC to release any information to consulting medical providers, insurance companies or any third party payor so that they may obtain payment for medical services rendered. I authorize the insurance companies or any third party to pay any benefits directly to the providers of CMC, realizing that I am responsible for all non-covered services. **Veterans will not be billed for services rendered.**

_____
Printed name of patient or person authorized to consent for patient

_____ Date: ____/____/____
Signature of Patient or person authorized to consent for patient

I do hereby give my consent for CMC to provide medical care and treatment to that is considered necessary and proper in diagnosing or treating a physical and/or mental condition. I also understand that CMC uses an electronic prescribing system to streamline past, current, and future prescriptions to prevent prescribing errors and that previous electronic prescription information may be collected.

_____
Printed name of patient

_____ Date: ____/____/____
Signature of Patient or legal guardian

No-show appointments will be subject to a $50 no show fee. Cancellations made less than 24 hours before the scheduled appointment time will be subject to a $50 late cancellation fee.