

# Welcome



**Cornerstone Psychiatric Services, Inc**

**David M. Donahue, D.O.**

**David Fawks, A.R.N.P. ♦ Nina Cuttler, A.R.N.P.**

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Website: [www.cornerstonepsychiatric.com](http://www.cornerstonepsychiatric.com)

## 1 PATIENT INFORMATION

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_

First Name

M.I.

\_\_\_\_\_  
Last Name

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zipcode \_\_\_\_\_

Social Security # \_\_\_\_\_

Sex  M  F Age \_\_\_\_ Birthdate \_\_\_\_-\_\_\_\_-\_\_\_\_

Marital Status

Single  Married  Divorced  Separated  
 Widowed  Domestic Partner

Employment Status

Full-time  Part-time  Retired  Other \_\_\_\_\_

Employer/School Name \_\_\_\_\_

Occupation \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Contact Phone Number \_\_\_\_\_

May we contact this physician?  Yes  No

How were you referred to us?  
\_\_\_\_\_

Your Primary Pharmacy name & phone#:  
\_\_\_\_\_

## 3 PHONE NUMBERS

Home\* (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell\* (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work\* (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

*\*You authorize us to leave appointment reminder messages.*

### IN CASE OF EMERGENCY

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Contact Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## 2 INSURANCE / FINANCIAL INFO.

### Primary Insurance Co./Financial Responsibility

Aetna  BlueCross/BlueShield  
 Cigna  Magellan  United Healthcare (UBH)  
 Tricare  Medicare  **Self Pay**

Other: \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Full Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

**Secondary Ins. Co (if any)** \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group # \_\_\_\_\_

### INSURANCE ASSIGNMENT / SELF PAY AGREEMENT AUTHORIZATION TO RELEASE

I certify that I have insurance coverage with the primary insurance company and, if applicable, the secondary insurance company listed above and assign directly to "Cornerstone" Psychiatric Services, Inc. (including Dr. Donahue, David Fawks or Nina Cuttler), all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. 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. The above named Facility and/or Clinician may use my health care information to the above named insurance company(ies) 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 carrier, it is my responsibility to obtain such authorization.

X \_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Print name of Patient, Parent, Guardian or Personal Representative

Self  Parent  POA/Caregiver \_\_\_\_\_

Relationship of Patient (check one)

\_\_\_\_\_  
Date

## **4 PATIENT CONSENT FOR EVALUATION OR TREATMENT and CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Medical / Psychiatric care and treatment at Cornerstone Psychiatric Services may be provided by Physicians, Advanced Registered Nurse Practitioners (ARNP), Clinical Social Workers (LCSW) or other State of Florida recognized Behavioral Health Practitioners. I understand that clinicians David Fawks and Nina Cuttler 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 for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

I hereby give my consent for **Cornerstone Psychiatric Services and their Business Associate's** (such as medical billing company, collection agency, automated appointment reminder vendor, dictation service, electronic prescription vendor) to use and disclose protected health (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Cornerstone Psychiatric Services** describes such uses and disclosures more completely.)

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 **Brad Labath, Privacy Officer, 1790 E Venice Ave Ste 204, Venice, FL 34292.**

With this consent, **Cornerstone Psychiatric Services** may call my home, mobile or other alternative location and leave a message on voice mail, text message or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Cornerstone Psychiatric Services** may mail or e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

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). Special circumstances include response to court orders, suspicion of abuse, or identification of threat of harm to self or others.

**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 of the preceding information unless otherwise indicated. I have received the Cornerstone "Welcome Letter", "Patient Rights and Responsibilities" and "Notice of Privacy Practices".**

**X**

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

# 5 PSYCHOSOCIAL / HEALTH SCREENING INFORMATION

The following information is provided by:

- Patient
  Family
  Other: \_\_\_\_\_

**Presenting symptoms:**

<input type="checkbox"/> Decreased Energy	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Memory Problem	<input type="checkbox"/> Isolation	<input type="checkbox"/> Depression	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Mania	<input type="checkbox"/> Anger / Temper	<input type="checkbox"/> Irritability	<input type="checkbox"/> Tearfulness	<input type="checkbox"/> Obsession
<input type="checkbox"/> Medication Effects	<input type="checkbox"/> Grief	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Euphoria	<input type="checkbox"/> Hopeless	<input type="checkbox"/> Other
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Guilt	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Confusion	<input type="checkbox"/> Helpless	
<input type="checkbox"/> Worthlessness	<input type="checkbox"/> Phobia	<input type="checkbox"/> Self - Injury	<input type="checkbox"/> Addiction	<input type="checkbox"/> Impulsivity	

Have you ever been treated for Mental Health Issues? ( ) Yes ( ) No

**Treatment History:**

Inpatient Mental Health (facility name and date of treatment): \_\_\_\_\_

Outpatient Mental Health (name of counselor / date of treatment): \_\_\_\_\_

**Stressors:**

- Support System
  Marriage
  Family
  Peer / Friendship
  Financial Problems
- Work Issues
  Disability
  Education Problems
  Health Problems
  Housing Problems
- Limited Resources
- Other: \_\_\_\_\_

**Substance Abuse History:**

- No History
  Alcohol
  Tobacco
  Caffeine
  Marijuana
- Prescription Drugs
  Crack Cocaine
  Other: \_\_\_\_\_

Treatment History Date(s) Inpatient: \_\_\_\_\_

Periods of Abstinence: \_\_\_\_\_

Length of Current Use: \_\_\_\_\_

Substance	Route	Age Started	Amount	Frequency	Lost Control?	Last Use

Loss of Control? ( ) Yes ( ) No
 Preoccupation? ( ) Yes ( ) No
 Tolerance Developed? ( ) Yes ( ) No
 Blackouts? ( ) Yes ( ) No

Family History of Substance Abuse: ( ) Yes ( ) No Relationship: \_\_\_\_\_

Withdrawal symptoms: ( )Tremors ( )Sweating ( )Seizures ( )D.T.'s ( )Anxiety ( )Tachycardia

Other: \_\_\_\_\_

**Medical History:**

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

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizures / Epilepsy
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Lung Disease / Breathing Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Cancer	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Glaucoma / Vision Problems	<input type="checkbox"/> Blood Disorders
<input type="checkbox"/> Other:			

**Surgical Procedures** (List procedure and indicate approximate dates):

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**Serious Injuries or Accidents** (List and indicate approximate dates):

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**Sleep Patterns:**

Hours each night: \_\_\_\_\_ ( )Awakens Frequently ( )Difficulty returning to sleep ( )Difficulty falling asleep

**Allergies:**

Please list all food and / or medication allergies below and any reactions you have had.

Food / Medication Allergy	Type of Reaction

**Current Medications:**

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: \_\_\_\_\_

Current Medication	Dose	Frequency	Last dose taken

**Family History:**

Please identify any blood relatives with a history of the following:

Illness	Relative(s)	Comments
Depression		
Anxiety / Panic Attacks		
Suicide Attempts		
Substance Abuse		
Alzheimer's Disease		
Bipolar Disorder		
Schizophrenia		
Heart Disease		
Seizures		
Stroke		

**Nutritional Assessment:**

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Without wanting to, have you lost / gained more than 10 lbs within the last 6 months?     Yes     No

Lost weight     Gained weight    Amount lost or gained: \_\_\_\_\_

**Functional Assessment:**

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

If yes, please describe: \_\_\_\_\_

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

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*Thank you*