

Welcome



Cornerstone Psychiatric Services, Inc
David M. Donahue, D.O.
David Fawks, A.R.N.P. ♦ Nina Cuttler, A.R.N.P.
1790 E. Venice Avenue, Ste. 204
Venice, FL 34292
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Website: 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#:

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 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 payor. 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 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

3 PHONE NUMBERS

Home* (____) _____ - _____ Cell* (____) _____ - _____

Work* (____) _____ - _____

*You authorize us to leave appointment reminder messages.

IN CASE OF EMERGENCY

Name _____ Relationship _____

Contact Number (____) _____ - _____

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 **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

PATIENT TO KEEP THIS PAGE

OFFICE POLICIES

Appointments

- Services are by appointment only.
- Payment is due at the time of service.
- Your appointment represents valuable time for both you and your clinician, we request that you notify us at least 24 hours in advance of a cancellation or need for change. If you fail to give the necessary 24-hour notice, a \$45 fee will be assessed to you. Insurance does not pay for missed appointments.
- You should be prompt for your scheduled appointments.

Initial Visit –New Patient

- New patients are required to bring completed 'Patient Registration' Form along with photo identification such as driver's license, insurance card(s) and a copy of any pertinent records from your previous treating provider.
- We highly recommend new patients establish with a Primary Care Provider (PCP) before being seen with one of our mental health providers.
- Please bring your current psychotropic medication prescription bottles with you at your initial appointment.

Prescriptions and Refills

- Prescriptions are sent electronically, and sometimes written or faxed, at the time of your appointment with sufficient quantities and refills, if necessary, to last until your next appointment. If by chance you run out of medication before your next appointment, please call our office or your pharmacy.
- Refill requests called in after 3:00 p.m. may not be sent to the pharmacy until the following business day.
- Prescription requests for Schedule II medications (i.e. Ritalin, Adderall, Concerta, Dexedrine, Vyvanse, etc.) must be requested at least one business day in advance for pick-up at the office.
- If you request the prescription to be mailed, please allow 5 business days to receive your prescription. Any lost prescriptions will NOT be renewed until next fill date. A \$3.00 administrative fee will be incurred for any prescriptions mailed. We only mail prescriptions to those patients living outside Sarasota County and under special circumstances authorized by your clinician.
- Patients that have been prescribed controlled substance medications are requested to use the same pharmacy each time for refills.
- Patients may be required to sign a Controlled Substance Agreement with this office.
- Controlled Substance prescriptions will only be sent for 30 day supply. We DO NOT send 90 day / 3 month supply for controlled substance medications to local or mail order pharmacies.

Forms, Letters, Telephone Calls & Email

- Patients will be billed for time spent filling out forms and dictation of letters. Minimum charge is \$25.00 per form, document or letter. This includes documents for disability. Insurance does not cover this expense.
- We reserve the right to bill you telephone calls between you and your clinician for the following reasons: excessive calls, you have not been in for an appointment for more than 90 days, you clinician requested we bill you for service provided.
- It is often difficult for our clinical staff to immediately respond to telephone calls. If your situation is urgent, please notify the receptionist at the time of your call and we will do our best to facilitate a timely response.
- As a courtesy, we have an automated appointment reminder system that will call one business day before your scheduled appointment. Again, this is done as a courtesy and not a requirement. You are responsible for showing up for your appointment.
- We do not have email capability between patient and this office due to privacy issues.

Financial Policy

- Payment is due at the time services are rendered.
- We will file your primary and secondary insurance on your behalf. We do not submit to a third or more insurance plan. You will be responsible in submitting the claim if any outstanding balance is due after the first and second insurance has processed the claim.
- Your insurance policy is a contract between you and your insurance company. Health insurance is intended to cover some, but, in many cases, not all of the cost of your treatment. You are responsible for co-payments, co-insurances, deductible and any balance remaining after your insurance has processed the claim.
- In the event of a returned check/NSF, a \$20.00 fee will be assessed to your account.
- We reserve the right to charge for missed appointments not called within 24-hours. The charge is \$45 billed to you. Insurance does not cover missed appointments.
- After three missed appointments, unfortunately we will have to terminate the patient-clinician relationship.
- Any accounts that are past due after 90 days are subject to being sent to our collections agency and may include termination of patient-clinician relationship.

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):

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

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?

Thank you