Cornerstone Family Practice
REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Ethnicity: ☐ Latin/Hispanic ☐ Asian ☐ White ☐ Alaskan Native/American Indian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Decline to offer ☐ Other

Language Spoken:	Birth date:	Age:	Sex: ☐ M ☐ F	E-mail:

Street address:	City:	State and zip:

Social Security no:	Home phone no:	Cell phone no:

Occupation:	Employer:	Employer phone no:

Other family members seen here:	Preferred Number to be contacted:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no:

Occupation:	Employer:	Employer phone:	Relationship to patient:

Name of Primary insurance and claims address:

Subscriber's name:	Group no:	Policy no:	SSN:	DOB:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no:	Policy no:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Contact phone no:

The above information in true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that i am financially responsible for any balance. I also authorize Cornerstone Family Practice or insurance company to release my information required to process my claims.

*Patient/Guardian signature:*________________________________ *Date:* ________________________________

*Staff Initials:*________________________________ *Date:* ________________________________

CORNERSTONE FAMILY PRACTICE

(Optional)

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize VERBAL disclosure of the named individual's health information as described below.

Patient Name	Date of Birth

Cornerstone Family Practice is authorized to verbally disciose protected health information (PHI) pertaining to my:

- ☐ Medical Status and/or Condition
- ☐ Financial/Insurance Related Information

Protected or sensitive information: I understand that certain information cannot be released without specific authorization **as required by State/Federal law. BY INITIALING I authorize the release of the following protected or sensitive information.**

- ☐ DRUG ABUSE DIAGNOSIS/TREATMENT
- ☐ ALCOHOLISM DIAGNOSIS/TREATMENT
- ☐ AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH RISK BEHAVIOR
- ☐ SEXUALLY TRANSMITTED DISEASES
- ☐ MENTAL HEALTH TREATMENT
- ☐ GENETIC TESTING

Cornerstone Family Practice may disclose verbally my PHI as marked above to the following individual(s) or organization(s):

Name:________________ **Relationship:**________________ **Telephone:** ________________

Name:________________ **Relationship:**________________ **Telephone:** ________________

Name:________________ **Relationship:**________________ **Telephone:** ________________

Name:________________ **Relationship:**________________ **Telephone:** ________________

Right to Revoke: I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Signature of Patient or Legal Representative	Date:

Cornerstone Family Practice

10001 South Eastern Ave., Suite 407,
Henderson, NV 89052 (P) 702-269-6345 (F) 702-269-9422
WWW.CORNERSTONE-FAMILYPRACTICE.COM

AUTHORIZATION - DISCLOSURE OF HEALTH INFORMATION

Release To:

Cornerstone Family Practice
10001 S. Eastern Ave., #407
Henderson, NV 89052
(702) 269-6345 / (702) 269-9422

Release From:

____
Name

____
Street Address, City, State, Zip

____
Phone/Fax Number

Information to be released:

☐ Office visits ☐ Procedure Reports ☐ Diagnostic Results ☐ Entire Record
☐ Consultations ☐ Laboratory Results ☐ Medications ☐ Billing
☐ Other (Specify) & Date Range:______________________________

Format to be provided: ☐ printed ☐ encrypted CD ☐ electronic PDF (patient only)

Information for continuation of care release via: ☐ mail ☐ fax (see below) ☐ in office pick up

Please indicate the reason you would like your health information released.

☐ Check here if you are the patient and you do not want to provide a reason.
☐ Check here if the release is not to the patient and provide the reason for the release here:

____

Your rights in regards to this authorization:

1) You have the right to refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment, payment, enrollment, or eligibility for benefits.2) I understand this consent may be revoked at any time, in writing and submit to our office, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation. 3) A photocopy of this authorization is to be considered as valid as the original. 4) I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of the authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization. 5) You have a right to obtain a copy of this authorization and any records obtained with its use. 6) You have the right to inspect or copy the health information authorized to be used or disclosed by this authorization. 7) You may contact our Privacy Officer at any time to arrange to inspect your health information or obtain copies. 8) Your health information that will be released as a result of you signing this authorization could be re-disclosed by the recipient. If this occurs, your re-disclosed health information may no longer be protected by state or federal privacy law.

Expiration: This authorization will automatically expire one (1) year from the date of execution unless a clifferent end date is specified. __________________

I have reviewed, understand and am voluntarily signing this authorization form.

Signature of Patient/Legal Representative: ______________________________ Date: _____________

______________________________ ________________
Printed Name of Patient/Previous names (print) **Birth Date**

If you are not the patient and are signing this authorization form, please list relationship and provide appropriate documentation to be attached to this form.

____

Patient/Representative Identification verified by CFP staff initials: ______

PLEASE FAX RECORDS TO:

Cornerstone Family Practice Attention:________________________________Fax: (702) 269-9422

Phone # (702) 269-6345 Address: 10001 South Eastern Ave, Suite 407, Henderson, NV 89052

Centennial Hills Hosp. 629-1300 Fx 629-1645	Desert Radiology-GV 387-6900 Fx 990-5342 / 794-2014	Desert Springs Hosp. 369-7704 Fx 369-7556	Del Mar Gardens 361-6111 Fx 361-2508	Harmon Rehab. 794-0100 Fx 893-6831
Kindred E. Flamingo 784-4300 Ext. 3026 Fx 784-4328	Lab Corp. (800) 788-9743 Fx 454-8184	Mountain View Hosp. 255-5048 Fx 255-5007	NPI 990-6900 Fx 933-4289	North Vista Hosp. 657-5533 Fx 649-1523
Quest Diagnostics 733-7688 ext 3 opt 3 Fx 733-6302	Silver Hills Rehab 952-2273 Fx 952-2270	Silver Ridge Rehab. 938-8329 Fx 938-7149	Spring Valley Hosp. 853-3191 Fx 853-3144	Southern Hills Hosp. 880-2130 Fx (866) 743-4266
Steinberg Diagnostics 732-6000 Fx 731-3879	St. Rose DeLima Hosp. 616-4642 Fx 616-4644	St. Rose San Martin Hosp. 492-8642 Fx 492-8165	St. Rose Siena Hosp. 616-5642 Fx 616-5235	Summerlin Hosp. 233-7581 Fx 233-7916
Sunrise Hosp. 731-8663 Fx 892-3686	Torrey Pines Rehab. 871-0005 Ext. 226 Fx 251-1161	UMC Hospital 383-2228 Fx 383-2012	Valley Hosp. 388-4580 Fx 388-4585	Vegas Valley Rehab. 735-7179 Fx 699-8576

Name____Phone___________________Fax______________

I hereby authorize any or all of the above parties to release to Cornerstone Family Practice my PHI (protected health information), including diagnosis, records of treatment, consultation or examination, diagnostic laboratory testing results, radiology reports, ancillary testing reports, including mental health/substance abuse or HIV/AIDS related treatment rendered to me on the following dates listed below. I understand that Cornerstone Family Practice might not be the ordering or referring physician for the above PHI (protected health information), but as my primary care physician, I request a copy be disclosed to said doctor. I also understand the signing of this joint release is for my convenience only and is not mandatory for treatment by Cornerstone Family Practice. I understand this release expires after 12 months and is revocable by me at any time.

Please send the following records as soon as possible for date (s)______________________________/most recent:

☐ History and Physical	Lab Reports	ETT/Regular-Cardiolyte	Echocardiogram
Transfer Summary	Xray of ____________	MRI of ______________	Specialty Consultatons______
Discharge Summary	US of _____________	CT of ______________	All Records

Other ____

To Be Filled Out By Patient/Responsible Party:

Print Name______________________________________Date of Birth____________SS# ______________

Address____Phone # ____________________________

X ____ ______________________________

Patient or Responsible Party Signature Date

Cornerstone Family Practice
Advanced Directives

Adults 18 years and older have the right to make decisions regarding their own health care. They may accept or refuse care based on their own desires. The best time to determine what the decision will be regarding the choice of healthcare is before being admitted to a health care facility. In the event a person loses the ability to make these decisions, there are !'..vo legal documents that protect their right to refuse unwanted medical treatment, or to request treatment that is wanted.

These documents are called:

Advanced Directives

There are two forms of Advanced Directives that are acknowledged in Nevada.

1. Declaration (Living Will) NRS 449.535-449.720

The declaration (living will) is in effect only when the attending physician determines the patient's condition is terminal and there is no chance of recovery. The declaration (living will) allows a person to state their wishes about the medical care in the event they develop a terminal condition and can no longer make their own medical decisions.

2. Durable Power of Attorney NRS 449.800-449.860

The durable power of attorney for health care allows a person to name someone else to make decisions abut their medical care, including decisions about life support, if they can no longer speak for themselves. This appointed person may make decisions regarding health care if a condition renders the patient: it does not require the condition to be terminal.

In the case a person has not prepared an Advanced Directive or to ask questions, you may have to contact the following resources:

Choice in dying
800-989-9455
www.lastactpartnership.org

Because the Durable Power of Attorney for Healthcare decision is a legal document, you may want to contact an attorney.

***Providers of service are required to inform their patients of their right to formulate an Advanced Directive, prior rendering medical treatment that requires a consent form and to document in the Patient's Medical Record whether an Advanced Directive has been executed.

I have an Advanced Directive ( ) Yes ( ) No

If you have an Advanced Directive, please provide a copy to the office for your chart.

Patient Signature ________________________________Date _____________

CORNERSTONE FAMILY PRACTICE

Today's Visit

Please fill out as much as possible. If something does not apply, please state so.
Thank you.

Date: ______________________________

Patient Name: ____

Date of Birth: ____

Main Reason for my visit today: ____

____

____

Other concerns I would like to discuss if there is time:_________________________________

____

____

Check all that apply:

___________ I have prescriptions that need to be refilled. Please list them below:

____

____

____

___________ I need a school or work excuse

___________ I need the attached forms filled out.

There is a fee for forms to be filled out. Forms will be filled out at the discretion of the provider. Our office will call you when the forms are ready to be picked up.

___________ I need a referral for: ____

___________ I would appreciate prayer today.

Please provide us with your pharmacy information for your permanent record. Thank You!

Name:____

Address:____

Phone: _____ ____________________________Fax: _____ ______________________________

CORNERSTONE FAMILY PRACTICE - PATIENT HEALTH HISTORY

Date: ______________

Name:____ Date of Birth: _____________________
(Last) (First) (MI)

SIGNIFICANT ILLNESSES

Do you or have you had : (please circle)

	Y	N
Diabetes 1 or 2	☐	☐
Cancer of ___________	☐	☐
Gout	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Kidney Disease	☐	☐
Anxiety or Depression	☐	☐
Stroke or TIA	☐	☐
Asthma or COPD	☐	☐
High Cholesterol	☐	☐

Other Illness not listed: _____________

Hospitalizations/ Surgeries

List all reasons you were hospitalized	Year
1. ______________________	______
2. ______________________	______
3. ______________________	______
4. ______________________	______
5. ______________________	______

FAMILY MEDICAL HISTORY

Has any blood relative including children, had any of the following:

	Y	N	Relationship?
Anemia	☐	☐	________________
Cancer of ________	☐	☐	________________
Diabetes	☐	☐	________________
Epilepsy	☐	☐	________________
Heart Disease	☐	☐	________________
High Cholesterol	☐	☐	________________
Stroke	☐	☐	________________
Tuberculosis	☐	☐	________________
Colon Polyps	☐	☐	________________
Asthma or COPD	☐	☐	________________

HEALTH SCREENING

Have you had:	Y	N	Date of Last ?
Physical	☐	☐	____________
Annual Eye Exam	☐	☐	____________
Pap smear	☐	☐	____________
Mammogram	☐	☐	____________
Bone Density	☐	☐	____________
Colonoscopy	☐	☐	____________
Chest x-ray	☐	☐	____________
Tetanus Shot	☐	☐	____________
MMR Shot	☐	☐	____________
TB test	☐	☐	____________
Prostate Exam	☐	☐	____________
EKG	☐	☐	____________
Hepatitis Vaccine	☐	☐	____________
Pneumonia Vaccine	☐	☐	____________
Flu Vaccine	☐	☐	____________
Shingles Vaccine	☐	☐	____________

SOCIAL HISTORY

	Y	N	
Tobacco History	☐	☐	#years____#cigs_____
Alcohol	☐	☐	Drinks/week________
Caffeine	☐	☐	cups/cans per week___
Recreational Drugs	☐	☐	times per week_____
Exercise	☐	☐	times per week_____

ALL ALLERGIES (medications/food/etc)

ALL ALLERGIES	REACTION
1. ______________________________	__________
2. ______________________________	__________
3. ______________________________	__________

MEDICATIONS

(List all medications you take on a regular basis including over the counter medications)

1.______________________________ 7. ______________________________
2.______________________________ 8. ______________________________
3.______________________________ 9. ______________________________
4.______________________________ 10.______________________________
5.______________________________ 11.______________________________
6.______________________________ 12.______________________________

Your Pharmacy____________________ **Location/Phone #** ______________________________

HEALTH HISTORY

Confidential

Patient Name:______________________________ Today's Date:____________________

Age:__________ Date of Birth:______________ Date of last physical examination: ____________________

What is your reason for visit?____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulder

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other: ______________

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other: ______________

Date of last menstrual period: __________

Date of last Pap Smear: ____________

Have you had a mammogram? ________

Are you pregnant? ________

Number of children: ________

CONDITIONS Check (√) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

MEDICATIONS List medications you are currently taking.	**ALLERGIES** To medications or substances.
Pharmacy Name: Phone:	

Cornerstone Family Practice
10001 S Eastern Ave, Suite 407
Henderson, NV 89052
Tel (702) 269-6345 Fax (702) 269-9422

Thank you for choosing Cornerstone Family Practice to meet all of your primary care needs. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered , we have developed this payment policy. Please read it, ask us any questions you may have, sign the attached sheet and return it to the front desk. This copy is yours to keep.

PAYMENT POLICY

1. **Insurance.** We participate in Medicare and most PPO insurance plans. If you are not insured by a plan we do business with, payment is due in full at each visit. If you are insured by a plan that we do conduct business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.

2. **Proof of insurance.** All patients must submit a completed copy of our patient information form before seeing the provider. We will need a copy of your driver's license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, or if we are unable to verify your insurance coverage, you will be responsible for payment at the time of service and or any balances due.

3. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement *is part your contract with your insurance company.* Failure on our part to collect co-payments and deductibles from patients can be considered insurance fraud.

4. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be considered non-covered benefits by your insurance company, or may not be considered reasonable and customary by Medicare or other insurers. **Ultimately all charges for services rendered are the responsibility of the patient or Guarantor.**

5. **Claims submission .** We will submit your claims to your insurance company **filL! courtesy to you.** We will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information to them directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your**

insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not subiect to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. **If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.**

7. **Nonpayment.** If your account is **over 90 days past due, it will be placed with a collection agency.** Once placed in collections, all fees incurred in collecting the debt, including any legal fees, will be added to the patients balance, and become the responsibility of the patient or guarantor. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, you and your immediate family members may be discharged from this practice. If this were to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments.** After three no show appointments, you may be dismissed from the practice. Please help us to serve you better by keeping your regularly scheduled appointment. **Any patient who does not show up for his/her appointment and does not call 24 hours in advance to cancel mav be billed a $25.00 no show fee.** Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

If you have any additional questions please refer to the *Fair Debt Collection Practices Act.* (FairDebtCol!ection .com)

Thank you for understanding our payment policy. Please let us know if you have any questions or concems.

Sincerely,

Cornerstone Family Practice

Comerstone Family Practice (CFP)
10001 S Eastem Ave Suite 407
Henderson. NV 89052
Tel (702) 269-6345 Fax (702) 269-9422

____ I have read and understand CFP's payment policy.

____ I understand that I am ultimately responsible for all charges incurred from services I receive.

____ I agree to pay any amounts owed in a timely matter.

____ I understand that if I do not call and cancel my appointment 24 hours in advance, I may be billed a $25.00 no show fee.

____ I hereby grant permission to CFP my consent for general care and to employ such treatments and therapy as may be deemed necessary and advisable.

- - I authorize CFP to give any and all information contained in my medical record to any physician that I am referred to and/or insurance companies or other agencies to which claim is made for payment of medical ser,ices.

____ I authorize CFP to look at my external prescription history, allowing them to see all prescriptions that have been filled.

____ I have been offered the Notice of Privacy Practices

____ I understand I need to follow the treatment plan agreed upon by my healthcare provider and myself. I acknowledge if I do not comply with the agreed treatment plan it may result in the termination of the patient-physician relationship.

______________________________ ______________________

Patient's/Legal Guardian's Signature **Date**

____

Patient's Printed Name