

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 Number: _____ Adjuster name & Number: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Phone: _____ Alternate Phone: _____

Would you like this contact to be your authorized HIPAA designee? ____ Yes (Access listed below) ____ No

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

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

1825 Academy Drive
Anchorage, AK 99508
Phone: (907) 522-7090
Fax: (907) 339-8786
cornerstoneclinic.org

PLEASE SEE OTHER SIDE 

CORNERSTONE MEDICAL CLINIC

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

Signature of Patient or person authorized to consent for patient

Date: ____/____/____

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

Signature of Patient or legal guardian

Date: ____/____/____

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.

1825 Academy Drive
Anchorage, AK 99508
Phone: (907) 522-7090
Fax: (907) 339-8786
cornerstoneclinic.org