cornerstone
WELLNESS CENTER
your center for wellness

Health Care Information Authorization

At times our office may need to contact you with appointment information about treatment or other health related information. By signing below, you are giving ***Cornerstone Wellness Center authorization*** to contact you by the following:

(Please draw a single line through any methods you REFUSE and initial)

- ✓ **I may be contacted by** home, work, or cell phone.
- ✓ **Messages may be left** on my home, work, or cell voicemail OR to any individuals answering my phone at home or work.
- ✓ **Also I may be contact by postal mail or e-mail** to send personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders. With my permission, my name and or photograph may be used for office events, bulletin board, newsletters or patient testimonials

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of ***Cornerstone Wellness Center.*** The written notice must contain the following information:

- Your name, social security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by ***Cornerstone Wellness Center*** for its own use/disclosure of protected health information. (Minimum necessary standards apply.)You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, ***Cornerstone Wellness Center*** will not refuse to provide treatment. You have the right to inspect or copy the protected health information to be used/ disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU **

PERSONAL REPRESENTATIVES (family members, attorneys, etc. I hereby authorize ***Cornerstone Wellness Center*** and its employee's permission to discuss, send and/or receive medical information to/with the following individuals:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

We like to co-manage your case with your Primary Care Physician; do you authorize us to send notes or records to them? YES NO

If Yes, please provide us the following information: Primary Care Doctor _____ Office Phone # _____

My signature below indicates that I have read and agree to the above authorization and I acknowledge that I have read a copy of ***Cornerstone Wellness Center*** Notice of Privacy Practices.

_____ _____
Patient Name Printed Personal Representative Name Printed

_____ _____
Patient Signature Signature of Personal Representative

_____ _____
Date Description of Personal Representative Authority to act for Patient

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Office Policy, Procedures & Disclosures

Medical/Chiropractic Department:

(Please initial next to each item below)

_____I understand that there is a $35 charge for missed appointments without a 24 hour advance notice for any appointment with the Chiropractic physician, Physical therapist and/or the Massage Therapist

_____ I understand that the patient is ultimately responsible for full payment for their treatment and care. Your insurance Policy is a contract between you and your insurance. As a courtesy, we check your insurance or superbill. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payments of co pays, co-insurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for explanation of any services not covered. Payment is due at the time of service, and for your convenience, we accept cash, and most major credit and debit cards at our office. Some insurance companies send you the provider's checks; you as the patient are responsible to bring those checks to our office with the EOBS as soon as you receive them.

Massage Department:

(Please initial next to each item below)

_____I understand that there is a 24 hour cancellation policy for ALL massages.

_____ I understand that I lose one massage from my package if I do not cancel 24 hours before the scheduled massage.

_____ I understand that I will be charged the $35.00 if I do not cancel 24 hours before the scheduled massage.

Miscellaneous:

_____ I understand that there is a $25 charge for forms completion by our Providers, including but not limited to disability and FMLA forms

Consent to care

_____As a patient with ***Cornerstone Wellness Center,*** you have the right to know the types of treatment we could possibly use and any complication/side-effects to such treatment. The procedures performed in our clinic are usually beneficial, however unexpected issues may arise. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not provide specific treatments if he/she is aware that such care may be contraindicated. I am responsible for informing my doctors about any conditions, diseases, illnesses, ect. I agree to settle any claim or dispute against or with our clinic or personal, were related to the prescribed care of otherwise, by binding arbitration under current malpractice terms which can be obtained by written request. Cornerstone Wellness Center may refer you out to other ancillary services that Cornerstone Wellness Center may have ownership to. I hereby allow treatment to be rendered to myself by all ***Cornerstone Wellness Center, physicians or staff.***

Financial Policy

_____I agree that any insurance checks sent directly to me or insurance policy holder for services rendered with *Cornerstone Wellness Center* will be brought into our clinic.

_____ I the undersigned, assign directly to Cornerstone Pain Management LLC (dba *Cornerstone Wellness Center)* all insurance benefits, if any, payable for services rendered to my minor child or myself. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of healthcare information and records to all insurance companies and to other treating providers whom i am seeking care from.

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I have read, understand, and agree to the provisions of this Patient Financial Responsibility and Disclosure Form:
Please sign/date below:

Printed Patient Name: _____ Date: _____

Signature of Patient: _____ Witness:_____