Cornerstone
Psychological Associates, PLLC

PATIENT INFORMATION

Date: _____

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	Sex ☐ Male ☐ Female	PATIENT DATE OF BIRTH

ADDRESS	CITY, STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	EMAIL ADDRESS

Which methods can we use to contact you? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

PATIENT SSN	MARITAL STATUS ☐ Single ☐ Married ☐ Other_____	EMPLOYER NAME/ADDRESS

GUARDIAN INFORMATION IF PATIENT IS A MINOR RELATIONSHIP TO PATIENT: ☐parent ☐ guardian ☐other _____

NAME (LAST, FIRST, MIDDLE INITIAL	ADDRESS (if different from patient)

CELL PHONE	WORK PHONE	EMPLOYER	EMAIL ADDRESS

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH

ID NUMBER	CO-PAY AMOUNT	Authorization (if needed)

SECONDARY INSURANCE NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH

ID NUMBER	CO-PAY AMOUNT	

EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

Have you seen any other Mental Health Provider in the last year?

Referral Source (How did you get our name)?

ASSIGNMENT AND RELEASE: I hereby authorize Cornerstone Psychological Associates, PLLC to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I also hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Cornerstone Psychological Associates, PLLC. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original. I certify that the insurance information supplied is correct. I understand that I will be responsible for any services not covered by insurance.	**ACKNOWLEDGEMENT- AGREEMENT & PRIVACY:** I have read and understand the Counselor Patient Services Agreement and have been provided the opportunity to discuss any area addressed in the Agreement or other concerns related to my treatment (or treatment of my minor child). My signature below confirms that I agree to the Agreement's terms and also serves as an acknowledgement that I have received or reviewed the HIPAA Privacy Notice Form described in the Agreement.

SIGNATURE: (Patient - age 14 and older)	DATE

SIGNATURE: (If patient is a minor, Signature of parent or guardian)	DATE