CORNERSTONE FAMILY MEDICINE

Chad A. Griffin, MD Anna Benningfield, APN Kelly Lyons, APN

Name: _____ Date _____

Address_____ City_____ ST_____ Zip_____

Home Phone ( )_____ Work ( )_____ Cell #( )_____

DOB:_____ SS#_____-_____-_____ **(√) [] M [] S [] W [] D**

(√) [] Male [] Female **(√) [] White [] Black [] Asian [] Bi-racial**

(√) [] Hispanic [] Non-Hispanic **Primary Language**: _____

E-Mail Address: _____

PARENT INFORMATION:

Mother's Name_____DOB_____SSN_____

Father's Name_____DOB_____SSN_____

IF INSURANCE DOES NOT PAY COMPLETELY, PERSON RESPONSIBLE FOR BALANCE

Name _____ SS#___-___-____ DOB:_____

Address _____ Phone _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

_____Relationship _____Phone _____

Authorizations

I understand that I am financially responsible for services rendered by the physician and his staff regardless of insurance, including reasonable attorney's fees and costs of collection in the event of default. I authorize my insurance company to pay benefits directly to Cornerstone Family Medicine, LLC or my physician.

I hereby authorize the release of information concerning my medical records, including the diagnosis and records of any treatment, laboratory test, or examinations, Photostat or faxed to Cornerstone Family Medicine, LLC or my physician to any agency requiring records for processing Medicare, Tenncare and insurance claims.

IF APPLICABLE: I give consent for the above patient, who is either under the age of 18 or requires legal custodian, to receive any treatment that is deemed necessary by Cornerstone Family Medicine, LLC.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. These authorizations apply to all occasions until revoked. My signature indicates that I have read the above and grant to request of authorizations.

Signature _____ **Date**_____

Cornerstone Family Medicine, LLC

433 Sewell Drive
Sparta, TN 38583
Phone: 931-739-3000 Fax: 931-739-3013

Chad A. Griffin, MD, FAAFP
Anna V. Benningfield, APN
Kelly Lyons, APN

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations.

PATIENT NAME:_____ **DOB**_____

Physician/Office to Release Records:

_____
_____
_____

Information Sent To:

Dr. Griffin
433 Sewell Dr.
Sparta, TN 38583

INFORMATION TO BE RELEASED: (please specify one)

1. **ALL RECORDS GENERATED BY THIS FACILITY:** _____
2. **ALL ABOVE INFORMATION EXCEPT:** Substance Abuse____, Mental Health____, AIDS/HIV____, Other_____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure if information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for the disclosure of information created for the sole purpose of disclosure to a third party, any result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

Patient's initials _____

A copy of this form will be provided if requested.
Cornerstone Family Medicine will not receive financial or in kind compensation in exchange for using or disclosing the health information described above. Expiration or revocation of authorization. I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Patient Name (please print) _____

Patient Signature _____

Date _____

CORNERSTONE FAMILY MEDICINE

Acknowledgement of Living Wills and Durable Power of Attorney

I have received a copy of the Living Wills and Durable Powers of Attorney for Health Care paperwork. I understand this is for information purposes only, if I wish to execute a Living Will or a Durable Power of Attorney I can contact an attorney to help me in this matter.

_____ **If you have a living will** (need a copy of it) or like to receive information on getting a living will please initial here.

_____ **I would** like information regarding a living will.

_____ **If you decline** a living will please initial here.

Signature Date

ONE-TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Cornerstone Family Medicine, LLC (Dr. Chad Griffin) for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date:_____

Signature:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Cornerstone Family Medicine's ***Notice of Privacy Practices*** containing a description of the uses and disclosures of my health information. I further understand that Cornerstone Family Medicine may update its ***Notice of Privacy Practices*** at any time and that I may receive an updated copy of Cornerstone Family Medicine's ***Notice of Privacy Practices*** by submitting a request in writing for a current copy of Cornerstone Family Medicine's ***Notice of Privacy Practices***.

_____

Printed Patient Name

_____ _____

Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____

Printed Patient Personal Representative Name Relationship to Patient

_____ _____

Patient Personal Representative Signature Date

For Cornerstone Family Medicine Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Cornerstone Family Medicine made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other_____

_____ _____

Employee Signature Date

Cornerstone Family Medicine, LLC

IMPORTANT NOTE TO PATIENT'S

PLEASE READ

The new HIPAA Law protects your right to privacy. We ***cannot*** provide any information to family and/or friends about you or your health status (i.e. test results, xrays, surgeries, office visits, etc.) unless you give us written permission. Without your authorization, we can only provide your health information to those listed in the **Notice of Privacy Practices**. If you would like for relatives, friends or other individuals to have access to your information (health status, test results, etc), a **signed** release form **must** be completed. By completing the attached form you are authorizing Cornerstone Family Medicine, LCC to provide your health information (per your instructions) to those you have listed. You have the right to revoke this release at any time by notifying our medical records department. If you have any questions you may ask the nurse or contact the HIPAA Privacy Officer.

To Whom May We Release Your Records: **(Ex: Spouse, Children, Parents or Guardians)**

1. _____
2. _____
3. _____
4. _____
5. _____

Patient/Parent Signature: _____
DOB: _____

AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication,
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and setting, including the following:
  Referrals to other health care providers,
  Follow up after I visit an emergency department,
  Follow up after I am discharged from the hospital or other facility
- Coordination with home- and community-based provider of clinical services

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish me chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that **Cornerstone Family Medicine** is designated as my primary care physician for purposes of providing Medicare chronic care management services to me and billing for them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient name (please print): _____
Patient signature: _____
Date: _____