

# Cornerstone Family Health Clinic Patient Registration Information

Please **PRINT AND** complete ALL sections below... Thank You.

## PERSONAL INFORMATION

**Marital Status:**  Single  Married  Divorced  Widowed **Sex:**  Male  Female

Name: \_\_\_\_\_  
last name first name initial

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Driver's License No.: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email Address: \_\_\_\_\_

## INSURANCE INFORMATION

Please present insurance cards to the front desk.

PRIMARY Insurance Name: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to insured:  Self  Spouse  
 Child  Other

Policy Number: \_\_\_\_\_ Group No: \_\_\_\_\_

SECONDARY Insurance Name (IF APPLICABLE) \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to insured:  Self  Spouse  
 Child  Other

Policy Number: \_\_\_\_\_ Group No.: \_\_\_\_\_

## EMERGENCY INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

## Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Cornerstone Family Health Clinic for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Parent Signature (if patient is under 18): \_\_\_\_\_

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of Cornerstone Family Health Clinic's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Cornerstone Family Health Clinic has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Cornerstone Family Health Clinic.

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Parent Signature (if patient is under 18): \_\_\_\_\_

Cornerstone Family Health Clinic  
13115 121<sup>st</sup> Way NE, Ste. C  
Kirkland, WA 98034  
Phone: 425-821-1800 – Fax: 425-821-1818  
www.cornerstonehealthclinic.com

**Naturopathic Medicine  
Informed Consent for Treatment**

I, \_\_\_\_\_, hereby authorize Cornerstone Family Health Clinic to perform the following procedures, but not limited to, to facilitate my diagnosis and treatment:

**Common diagnostic procedures:** e.g., venipuncture, Pap smears, laboratory, diagnostic imaging.

**Minor office procedures:** e.g., cleaning, dressing a wound, ear lavage, skin scraping, skin cryotherapy, sutures.

**Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections, intravenous nutrition.

**Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.

**Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

**Lifestyle counseling and hygiene:** diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

**Vaccinations, Psychological Counseling, Contraception, Pharmaceutical prescriptions**

**I recognize the potential risks and benefits of these procedures as described below:**

**Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures. Notify the staff of Cornerstone Family Health Clinic if you experience any symptoms which may be secondary to the above procedures.

**Potential benefits:** restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

**Notice to Pregnant Women:** all female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

**Notice of Allergies:** all patients must alert the doctor if they have any known or suspected allergies (environmental, food, drug, etc.).

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Cornerstone Family Health Clinic or any personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative or Guardian

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## **Financial Policy and Fees**

We are honored to be a part of your health care team and we promise to provide you with the highest quality medical care. We feel that is extremely important that you have a clear understanding of our expectations regarding billing and payment. Please read and sign the following financial policy prior to your first visit. If you have any questions or would like an explanation, please feel free to ask.

**1. INSURANCE:** Your insurance policy is a contract between you and your insurance carrier. It is your responsibility to know what your policy covers and what it does not. If your insurance plan requires that you have a referral to see us, it is your responsibility to make sure that you have a referral on file with your insurance company before your appointment. If your insurance has naturopathic medical benefits, acupuncture and/or mental health benefits, we will gladly bill them for you. You are responsible for the co-pay, deductible and payment for non covered services as payment in full. **Co-payments MUST BE made at the time of service or there will be a \$15 charge.**

\_\_\_\_\_  
Initial

**2. FEES:** Charges and fees for your care are based on values created by the American Medical Association and is adopted by most insurance companies. Medical billing depends **upon the complexity**, not the time spent with each patient. You are welcome to know what the charge is for any given service.

\_\_\_\_\_  
Initial

**3. NON-COVERED SERVICES:** There are several services that Cornerstone Family Health Clinic provides for you that may or may not be covered by your insurance company. Although these services are not required for your care, they may be important for you: Some examples of non-covered services include emergency pager fees, telephone conferences and email visits. **Although these fees can vary depending upon the complexity, a typical emergency pager fee can start at \$25, a telephone conference ranges between \$90-\$200, and an e-mail fee ranges between \$25-\$125.**

\_\_\_\_\_  
Initial

**4. PAYMENT POLICY:** Payment is expected at the time of service. This includes any co-pay, fees not covered by your insurance, pharmacy fees, etc. Keep in mind that you will receive statements from Cornerstone Family Health Clinic to keep your account current. **A \$5 rebilling fee** will be assessed if there is a failure to make a payment or make contact with Cornerstone Family Health Clinic. If your account is over 90 days past due, you will receive a letter stating that you have a specified amount of time to make payment arrangements. Failure to make payment arrangements will result in your account being referred to a collection agency and you may be immediately discharged from this practice. **A \$5-\$25 fee** will be charged to all non-sufficient funds (NSF). When a minor is seen at Cornerstone Family Health Clinic, payment is expected from whoever accompanies the minor to the visit.

\_\_\_\_\_  
Initial

**5. APPOINTMENTS:** A missed appointment is a loss to everyone. Please give 24 hours notice if you are unable to keep your appointment; otherwise we reserve the right to charge for the time reserved (**\$50-\$135**). This charge is **your responsibility**, as insurance companies do not pay for missed appointments.

\_\_\_\_\_  
Initial

**I acknowledge that I have read and fully understand this financial policy. I agree to the above states fees and charges and all of my questions have been answered.**

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date signed

# Cornerstone Family Health Clinic

Dr. Mark Monwai Dr. Chris Cotner Dr. Christine James Tracie Carlson, MA, LMHC  
Tammy Ferguson, MA, LMHC Teresa Jansen, MSAOM, LAC Brian Pendergast, MA, LMHCA

13115 121<sup>st</sup> Way NE, Suite C, Kirkland, WA 98034  
Phone: 425-821-1800 Fax: 425-821-1818  
www.cornerstonehealthclinic.com

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

**Patient's  
Name:** \_\_\_\_\_

**Date of  
Birth:** \_\_\_\_\_

I request/authorize \_\_\_\_\_ to release healthcare information to

NAME: CORNERSTONE FAMILY HEALTH CLINIC, LLC

ADDRESS: 13115 121<sup>ST</sup> WAY NE SUITE C, KIRKLAND WASHINGTON 98034

PHONE: 425-821-1800

FAX: 425-821-1818

EMAIL: info@cornerstonehealthclinic.com

This request and authorization applies to:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Intake Evaluation        | <input type="checkbox"/> Treatment Plan        | <input type="checkbox"/> Crisis Plan        |
| <input type="checkbox"/> Medical Diagnosis        | <input type="checkbox"/> Laboratory Results    | <input type="checkbox"/> Discharge Summary  |
| <input type="checkbox"/> Medications              | <input type="checkbox"/> Entire Chart          | <input type="checkbox"/> Medical History    |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Progress Notes        | <input type="checkbox"/> Continuity of Care |
| <input type="checkbox"/> Scheduling               | <input type="checkbox"/> Financial Information | <input type="checkbox"/> Other:             |

**SPECIFIC AUTHORIZATIONS:** I understand that my record may contain information regarding mental health diagnosis and treatment, drug and/or alcohol abuse (Per 42CFR, Part 2), the testing diagnosis, or treatment of HIV/AIDS and/or sexually transmitted diseases (Per RCW 70.24.105). I give my specific authorization for these protected records to be released. {if you do not want these records released please complete section (a)}

(a)  I DO NOT want the following information to be released (if nothing is specified, all information will be included):

Patient  
Signature: \_\_\_\_\_

Date  
Signed: \_\_\_\_\_

Client  Parent  Legal Guardian  
(Client must sign own consent if 13 years old or older)

Representative Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Cornerstone Family Health Clinic**  
**Notice of Privacy Practices**

We respect our legal obligation to keep health information that identifies you private. As obligated by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We do not use your health information in our office or disclose it outside of our office without your written permission. In some limited situations, the law requires us to disclose your health information without either written or verbal consent.

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and healthcare operations in this office. We are allowed to refuse to treat you if you do not sign the consent form.

We are permitted to use and disclose your healthcare records for the purpose of treatment, payment, and healthcare operations:

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, we may need to share information with other providers or specialists involved in your care.
- Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a medical plan for you.
- Healthcare operations include the business aspects of running our practice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization or as permitted by law.

In some limited situations, the law requires us to use and disclose your health information without your permission. These examples may never come up at our office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by your insurance plan, or for investigation of possible violation of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosure related to worker's compensation programs.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information to any person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to ask us to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. We do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyers, healthcare research firm, etc). Please complete our written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is originally effective March 17, 2003 and revised on January 1, 2007. We are required to abide by the terms of this Notice of Privacy Practices and to make the new notice provisions effective for all protected healthcare information that we maintain. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our privacy practices:  
Cornerstone Family Health Clinic  
13115 NE 121<sup>st</sup> Way NE  
Suite C  
Kirkland, WA 98034  
425.821.1800

For more information on HIPAA or to file a complaint:  
The US Dept. of Health & Human Services  
Office of Civil Rights  
200 Independence Ave. SW  
Washington DC, 20201  
877.696.6775