CORNERSTONE
FAMILY HEALTH CARE
A Premier Health Partner

Anna Burson, M.D.
(580) 226-9994
ardmoreoffice@piptx.com

Demographic Information

Patient Name		**Date of Birth**	**Sex** Male / Female
Social Security Number	**Email**	**Marital Status** Single / Married / Widowed / Divorced /Other	
Mailing Address		**City/State**	**Zip Code**
Primary Phone	**Secondary Phone**	**How did you hear about us?** □Google □Physician Referral □Other: _____	

I authorize detailed messages containing pertinent medical information to be left in a voicemail at the following numbers:
□Primary Phone □ Secondary Phone □ Emergency Primary □ Emergency Secondary

Responsible Party □ Self □ Other – Information Below

Name		**Relationship to Patient**
Date of Birth	**Primary Phone**	**Mailing Address** [☐ Check if Same as Above]
Employer's Name		

Emergency Contact	**Emergency's Primary Phone**	**Emergency's Secondary Phone**
Pharmacy Name and Address	**Pharmacy Phone Number**	
Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown	**Language** □ English □Other_____	
Race □ American Indian or Alaska Native □ Asian □ White □Other □ Black or African American □ Native Hawaiian or Other Pacific Islander	**Appointment Confirmation Preference** □ Email □ Text	

Protected Health Information Authorization

Name	Relationship	Type of Information Authorized
1.		□All □Scheduling □Medical □Billing
2.		□All □Scheduling □Medical □Billing

I have reviewed the above information and authorize my protected health information to be released to the individuals listed, as specified. I understand that this authorization applies to both written and verbal communications. I also understand that I may request to revoke this authorization, in writing, at any time.

_____ _____
Signature of Patient/Legal Representative **Date**

Insurance Information

Primary	Secondary	Tertiary
Insurance Company	**Insurance Company**	**Insurance Company**
Name of Insured	**Name of Insured**	**Name of Insured**
Insured Date of Birth	**Insured Date of Birth**	**Insured Date of Birth**
Member ID/ Policy #	**Member ID/ Policy #**	**Member ID/ Policy #**
Group #	**Group #**	**Group #**

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Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check, cash, debit card, American Express, Discover, Mastercard, or Visa.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and you may be required to pay a copayment, coinsurance, or deductible at the time of service.

Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary care physician (PCP), or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the patients' share of the medical fees owed when using non-contracted physicians will usually be more than when using contracted physicians.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of the balance that is designated as the patients' responsibility is due upon receipt of a statement from our office.

Keep in touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. You will be held responsible for services not paid by your health plan.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, or the parent or guardian with custody, for payments.

I have read and understand the financial policy of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of Patient	Date of Birth
Signature of Patient/Legal Representative	Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed or have been given the opportunity to review this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

** If you would like to receive a copy of our Notice of Privacy Practice, please ask an associate.*

Printed Name of Patient	Date of Birth
Signature of Patient/Legal Representative	Date

Cancellation and No-Show Policy Acknowledgement

In an effort to minimize waiting periods and improve appointment availability we have found it necessary to enact a Patient Cancellation Policy. Any patient that cancels an appointment with less than 24-hour notice and/or does not show up for their appointment will be charged a fee of $35 for the missed appointment. Additionally, after 2 cancellations or no shows without adequate notice, we will no longer be able to accommodate schedule requests. We hope this policy will ultimately benefit all patients by improving the quality of your treatment experience.

I understand Premier Independent Physicians cancellation policy.

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Prescription Policy

Our practice is a medical office that treats many types of ailments and conditions. On occasion we may prescribe medications for you to help relieve pain. These medications, when used properly, can help patients feel better and lead productive lives. These medications can also be misused, causing harm to patients and to others. For this reason, the State of Oklahoma and the Federal Drug Enforcement Administration regulates use of these medications. Our practice follows those laws:

Our Policy:

1. Written prescriptions will not be replaced if lost, stolen, destroyed, or misplaced.
2. Prescriptions are to be taken as directed. In other words, DO NOT change the frequency of the dose unless otherwise directed by your physician. If a change does occur, this will be documented in your chart.
3. By law, controlled substances cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in our office in the past three months, prescriptions for the following cannot be refilled. Exceptions to this must be discussed with the physician during an office visit. Exceptions will not be granted over the phone.
    a. Sleep Aids such as Ambien or Lunesta
    b. Anti-inflammatories such as Celebrex, Ibuprofen, or Naproxen
    c. Narcotics such as Lortab, Vicodin, Darvocet, or Hydrocodone
    d. Muscle Relaxers such as Soma, Flexeril, or Robaxin.
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will NOT be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough medication.
7. Before you visit our practice, please check your supply of medication. If you need refills, please ask for them during your appointment.
8. Refill requests for hormone replacement and birth control pills can only be refilled if you have a routine gynecology appointment scheduled. Exceptions to this must be discussed with the physician during an office visit. Exceptions will not be granted over the phone.
9. Refill requests for prescriptions not prescribed by your physician will not be authorized.
10. At least 2 business days are needed for prescription request. Call before Friday.
11. Do not call more than once about a medication, refills, or any issue. When you call our office, a message is sent to your physician. Nothing can be done until your physician has a chance to review the message. The physician is the only one who can approve for your medication to be refilled.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescriptions refilled. I agree to abide by this policy and understand that this signed policy will be scanned into my chart.

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Authorized Release of Information

720 Grand Avenue
Ardmore, OK 73401

This is a release form for authorization of your medical information to be used/and or disclosed between health care providers health, insurance companies, and any other party involved in your medical care.

I, _____, hereby authorize The Facilities Listed below to release all medical information to Cornerstone Family Health Care, A Premier Health Partner.

This request includes: hospital summaries, laboratory reports, physician progress notes, and any other healthcare information relating to my condition.

**List facility name(s), hospital name(s) and/or physician(s) below where you would like your medical records sent.*

Facility / Provider Name	Fax Number

I hereby authorize the above -mentioned provider/facility to release and/or disclose the medical information as indicated below to: Premier Independent Physicians of Sanger. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health and alcohol and/or substance abuse,

DURATION- This information shall become effective immediately and shall remain in effect until ____/____/_____ or for ninety days from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED

( )Entire medical record ( )History and Physical ( )Chart Summary ( )Labs ( )Radiology ( )Pathology

( )Other (Please specify)_____

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purpose only:

( )Physician or Healthcare facility ( )Legal ( )Personal ( )Other _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

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NAME		DATE			
DOB		AGE		SEX	

BRIEFLY DESCRIBE YOUR PRESENT SYMPTOMS:

PAST PHYSCIAN/ HOSPITAL HISTORY

Allergies □ Yes □ No

Allergy: _____ _____ _____

What reactions did you have: _____ _____ _____

Name of Physician/Clinic	Duration of treatment (mo. or yr.)	Location (City/State)	Reason for treatment

Have you ever been hospitalized? □ Yes □ No If yes please fill in below:

Name of Hospital	Date of hospitalization	Location (City/State)	Reason for treatment

Immunizations: ***for children, provide a copy the current immunization record***

When was your last tetanus shot? _____

Hepatitis B Vaccine? _____

Flu Shot? _____

Pneumonia Shot? _____

For Women:

Number of Pregnancies: _____

Number of Deliveries; _____

Last Menstrual Period: _____

Last Pap Smear: _____

Last Mammogram: _____

What do you use for contraception? _____

For Men:

Manual Prostate Exam: _____

PSA Blood Test: _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ☐ Diabetes
- ☐ Heart murmur
- ☐ Crohn's disease
- ☐ High blood pressure
- ☐ Pneumonia
- ☐ Colitis
- ☐ High cholesterol
- ☐ Pulmonary embolism
- ☐ Reflux/ Heartburn
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Hypothyroidism
- ☐ Asthma
- ☐ Jaundice
- ☐ Goiter
- ☐ Emphysema/ COPD
- ☐ Hepatitis
- ☐ Cancer (type) _____
- ☐ Stroke
- ☐ Stomach or peptic ulcer
- ☐ Leukemia
- ☐ Migraine Headaches
- ☐ Depression
- ☐ Epilepsy (seizures)
- ☐ Rheumatic fever
- ☐ Psoriasis
- ☐ Cataracts
- ☐ Tuberculosis
- ☐ Angina
- ☐ Kidney disease
- ☐ HIV/AIDS
- ☐ Heart problems
- ☐ Kidney stones
- ☐ Hepatis
- ☐ Glaucoma
- ☐ Other pertinent history_____

Other medical conditions (please list):

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PAST SURGICAL HISTORY		TEST AND EXAMS
Please include date of surgery's. ☐ Tonsils: _____ ☐ Gallbladder: _____ ☐ Appendix: _____ ☐ Hysterectomy: _____ ☐ Heart: _____	☐ Lung: _____ ☐ Orthopedic (Bone) _____ ☐ C- Section: _____ ☐ Colon: _____ ☐ Bladder: _____ ☐ Hernia: _____ ☐ Breast: _____	☐ Sigmoid/ Colonoscopy: _____ ☐ Electrocardiogram: _____ ☐ Complete Physical: _____ ☐ Chest X-Ray: _____ ☐ Treadmill Stress: _____

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Please include name of drug, dose, how many times per day, and how long have you been taking this?

1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

SUBSTANCE ABUSE HISTORY

Are you a smoker? ☐ Yes ☐ No
If yes, how many packs do you smoke? _____ Any attempts to quit: _____
If you quit using, how long? _____

Do you consume alcohol? ☐ Yes ☐ No
How often do you drink? ☐ Weekly _____/wk ☐ Monthly _____/month ☐ Rarely _____
☐ Quit drinking _____(specify last usage)
Specify amount you drink in each setting: _____

Do you have a history of Substance Abuse? ☐ Yes ☐ No
Have you ever attended rehab? ☐ Yes ☐ No
If yes, Please state when and for treatment of what: _____

Substance	Quantity Used	Frequency of Use	Quit (Y/N)	Last Used

FAMILY HISTORY LIST BLOOD RELATIVES WHO HAVE BEEN DIAGNOSED WITH THE FOLLOWING CONDITIONS

Are your parents living? ☐ Yes ☐ No	**If not, what what the cause of death?**
Alcoholism	Heart Disease/High blood pressure/Irregular Heart rhythms
Anxiety disorders	Osteoporosis
Bipolar disorder	Seizures
Cancer	Schizophrenia
Depression	Stroke
Diabetes	Suicides
Drug abuse	Thyroid disease

SOCIAL HISTORY

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life/serious partner
How long have you been married? _____ Are you happy in your relationship: ☐ Yes ☐ No
Describe your relationship satisfaction: ☐ Not applicable ☐ Very Satisfied ☐ Somewhat satisfied ☐ Dissatisfied.
Any children: ☐ Yes ☐ No

Education History: What is your highest Level of education? _____

Employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Disabled ☐ Homemaker
Occupation: _____ Employer: _____ How long have you had this job: _____

Residential Status: ☐ Own a home ☐ Rent ☐ Live w/parents ☐ Foster Care ☐ Homeless ☐ Nursing Home Facility ☐ Live w/roommate(s)

Please check all stressors you are experiencing currently
☐ Economic/Financial ☐ Education/School ☐ Family Conflict ☐ Grief/Loss ☐ Legal Problems ☐ Medical Illness
☐ Work ☐ Living Situation ☐ Social Environment ☐ Substance Abuse ☐ Marital Conflict
☐ Family Disruption due to divorce or separation ☐ Personal Injury ☐ Relationship ☐ Environmental change