

CORNERSTONE PSYCHOLOGICAL SERVICES
4018 Medina Rd Ste D, Medina, Ohio 44256
330-722-4166

PATIENT INFORMATION

PATIENT FULL NAME				
ADDRESS (STREET)		CITY	STATE	ZIP
PHONE	SOCIAL SECURITY#		SEX MALE / FEMALE	DATE OF BIRTH
RELATIONSHIP STATUS SINGLE MARRIED PARTNERED WIDOWED DIVORCED		STUDENT STATUS FULL TIME PART-TIME		
EMPLOYER		WORK NUMBER		
ADDRESS (STREET)		CITY	STATE	ZIP

RESPONSIBLE PARTY INFORMATION (if patient is a minor)

RESPONSIBLE PARTY NAME		RELATIONSHIP TO PATIENT	MARITAL STATUS SINGLE MARRIED DIVORCED	
ADDRESS (STREET)		CITY	STATE	ZIP
PHONE	SOCIAL SECURITY #		SEX MALE FEMALE	BIRTH DATE
EMPLOYER			WORK PHONE	
ADDRESS (STREET)		CITY	STATE	ZIP

PRIMARY INSURANCE INFORMATION

ARE YOU ELIGIBLE FOR:							
IMPACT		YES	NO	OR	EAP SERVICES	YES	NO
NAME OF MEDICAL INSURANCE COMPANY							
POLICY HOLDER NAME			RELATIONSHIP TO PATIENT				
POLICY HOLDER ADDRESS (STREET)			CITY	STATE	ZIP		
PHONE #	SEX MALE FEMALE		BIRTH DATE	EMPLOYER OF POLICY HOLDER			
POLICY NUMBER	GROUP NUMBER			SOCIAL SECURITY NUMBER			

AGREEMENT, ASSIGNMENT OF BENEFITS, ASSUMPTION OF RESPONSIBILITY, & RECORDS TRANSFER AUTHORIZATION:

I hereby assign to Cornerstone Psychological Services, and its associated therapist and practitioners all benefits to which I am entitled from all private and public medical insurance plans including Medicare and Medicaid. I understand that I am financially responsible for all treatment charges for services rendered by any professional of Cornerstone regardless of any limitations of insurance coverage, divorce agreements, or victim's assistance. I understand that I will be charged for appointments missed unless 24 hour notice is given to your therapist or doctor. I understand all deductibles, and co-payments must be paid in full. Co-payments must be paid to your therapist at the time of service unless an "Agreement for Special Payment Arrangements" form has been completed and signed by you and your therapist. I understand if my coverage is part of a contractual arrangement between Cornerstone Psychological Services and a specific third party payer, Cornerstone agrees to abide by the regulations and reduced rates outlined in those counteracts. I hereby agree to the above and hereby authorize Cornerstone Psychological Services to release information about my condition and treatment to those who are part of the process of securing insurance payment for the same. I authorize payment to be made directly to Cornerstone for the therapist or doctor providing services. This assignment and authorization will remain in effect until revoked by me in writing. I acknowledge that a photo copy of this assignment and authorization is as valid as the original.

FAILURE TO SIGN THIS AGREEMENT WILL REQUIRE YOU PAY IN FULL AT THE TIME OF EACH VISIT

SIGNATURE OF FINANCIAL RESPONSIBILITY: _____ DATE: _____

SIGNATURE OF INSURED: _____ DATE: _____