CORNERSTONE PSYCHOLOGICAL SERVICES
4018 Medina Rd. Ste. D, Medina, Ohio 44256

PATIENT INFORMATION

PATIENT FULL NAME			
STREET ADDRESS	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	
STREET ADDRESS	CITY	STATE	ZIP

RESPONSIBLE PARTY INFORMATION (if patient is a minor)

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

PRIMARY INSURANCE INFORMATION

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 and Counseling Services of Northeast Ohio, LLC, 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. I understand all deductibles and co-payments must be paid in full at the time of visit. I understand if my coverage is part of a contractual arrangement between Cornerstone Psychological and Counseling Services of Northeast Ohio LLC 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 and Counseling Services of Northeast Ohio, LLC 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:_____
Revised June 1, 2016