Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)
Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address
Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan
Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

Reason for Visit

What brings you to the office today?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Allergies

Do you have any medication, food or environmental allergies?

Name	Reaction
Name	Reaction
Name	Reaction
Name	Reaction

Past Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS / HIV
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease/Problem
- ☐ Hepatitis - A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder/Stones
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Reflux
- ☐ Stroke
- ☐ Skin Disorder
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Testosterone Deficiency
- ☐ Thyroid Disorder
- ☐ Venereal Disease

Hospitalizations & Surgeries

Reason	Date
Reason	Date

Family History (Only Relatives)

Please specify any ***relatives*** who have ever had the following:

- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Psychiatric Disorders
- ☐ Stroke

Details:

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally abused you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years_____ # packs/day_____

Do you smoke now?

☐ Yes ☐ No # packs/day_____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week_____

How much alcohol do you drink per week?

drinks/week_____

How much caffeine do you drink per day?

drinks/day_____

How often do you exercise?

times/week_____

OBGYN History (Women Only)

Have you ever had or do you currently have any of the following?

- ☐ Abnormal Vaginal Bleeding
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Breast Cancer
- ☐ Breast Surgery
- ☐ Cervical Cancer
- ☐ Chlamydia
- ☐ Colposcopy
- ☐ Cryosurgery
- ☐ DES Exposure
- ☐ Extreme Menstrual Pain
- ☐ Fibroids
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Hot Flashes
- ☐ HPV
- ☐ Infertility
- ☐ Nipple Discharge
- ☐ Ovarian Cysts
- ☐ Ovarian Cancer
- ☐ Painful Intercourse
- ☐ Pelvic Inflammatory Disease
- ☐ Uterine Cancer
- ☐ Urinary Incontinence
- ☐ Yeast Infections – Frequent

Pregnancy History (Women Only)

Please describe any pregancies you have had.

_____ # of Pregnancies _____ # of Full Term _____ # of Miscarriages _____ # of Abortions

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Were there any complications associated with any of your pregnancies?

Are you currently pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

Do you need birth control or contraceptive advice? ☐ Yes ☐ No

What method of birth control do you use?

Menstrual History (Women Only)

When was the first day of your last period?

How often does your period occur?

How long does your period last?

Is your period regular? ☐ Yes ☐ No

Is your flow light, moderate or heavy?

What age were you when you had your first period?

What age were you at menopause?

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
☐ Colonoscopy		
☐ Dexascan (Bone Density)		
☐ Fecal Occult Blood Test		
☐ Flu Vaccine		
☐ HPV Vaccine		
☐ Mammogram		
☐ Pap Smear		
☐ Physical Exam		

Review of Systems

General

- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth –
- ☐ Excessive Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain/Loss

Cardiovascular

- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Gastrointestinal

- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating and Gas
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Blood in Stool
- ☐ Stomach Pain
- ☐ Vomiting

Genitourinary

- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Night Time Urination
- ☐ Difficulty with Erections (Men)

ENT

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Difficulty Swallowing
- ☐ Earaches
- ☐ Hay Fever
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Sinus Problems

Endocrine

- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Hot Flashes

Respiratory

- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Snoring

Skin

- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Facial Hair (Women)
- ☐ Rash
- ☐ Scars

Neurological

- ☐ Coordination Problems
- ☐ Difficulty Walking
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Tremors

Musculoskeletal

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

Mental Health

- ☐ Anxiety/Nervousness
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Loss of Sexual Interest
- ☐ Marital Problems
- ☐ Trouble Concentrating
- ☐ Suicidal Thoughts/Attempts

Other Symptoms

CornerStoneMD

Specialty Care Screening

Patient Name: _____

Do you have:	YES	NO	Would you like a specialty consultation (Y/N)?
Hot flashes	☐	☐	☐
Sweating (Night sweats, increased episodes of sweating).	☐	☐	☐
Sleep Problems (difficulty falling asleep, sleeping through the night, or waking up early).	☐	☐	☐
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension).	☐	☐	☐
Sexual Problems (Change in sexual desire, in sexual activity and/or orgasm and satisfaction).	☐	☐	☐
Problems with thinking or reasoning	☐	☐	☐
Weight Gain or difficulty losing weight despite diet and exercise	☐	☐	☐
Vaginal Dryness	☐	☐	☐
Painful Sex	☐	☐	☐
Urinary urgency or frequency	☐	☐	☐
Urine leakage with sneeze or cough	☐	☐	☐
Fine lines and wrinkles	☐	☐	☐
Loss of Lip/Face Volume	☐	☐	☐

12222 North Central Expy, Suite 140, Dallas, Tx 75243
Phone: (469) 840-8480 • Fax: (214) 575-8484

Please circle all that apply:

Yes / No Have you had surgery in the treatment area within the last 12 months?

Yes / No Do you have Implants in the treatment area?

Yes / No Do you have a history of herpes? Patients with history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area, may be treated only following a prophylactic regimen.

Yes / No Do you currently have a UTI?

Yes / No Do you currently or have you had a history of skin cancer and genital area cancer, or current condition of any other type of cancer, or pre-malignant moles?

Yes / No Any significant illness such as diabetes, cardiac disease, autoimmune disease?

Yes / No Do you have a history of epidermal or dermal disorders involving collagen or microvasculature?

Yes / No Do you have an active electrical implant in any region of the body?

Yes / No Are you currently pregnant and nursing?

Yes / No Do you have diseases of the immune system such as HIV, AIDS or immunosuppressive med?

Yes / No Use of anticoagulants or history of bleeding disorders?

Yes / No Any active condition in the treatment area, such as open lacerations, infection, abrasions or lesions, psoriasis, eczema or rashes?

Yes / No History of skin disorders, keloids, abnormal would healing?

Yes / No Tattoo in the treatment area?

Yes / No History of Accutane use in the previous 6 months?

Yes / No Have you received treatment with light, laser, RF, or other devices in the treated area within 2-3 weeks for non-ablative procedures, and 6-12 weeks for ablative fractional laser resurfacing (according to treatment severity) prior to treatment, except special recommendations?

Yes / No Use of non-steroidal anti-inflammatory drugs? (NSAIDS, e.g., ibuprofen-containing agents) one week before and after each treatment session, as per the practitioner's discretion.

Yes / No Excessively tanned skin in the treatment area from sun, sun-beds or tanning creams?

Yes / No Botox, Filler or any injections in the area to be treated? If yes, when? _____ (ID/Flex)

Yes / No Ever been to an Endocrinologist (Hormone Imbalance)? If yes, why? _____ (ID/Flex)

TruSculpt Flex
INFORMED CONSENT FORM

I hereby authorize employees of Cornerstone MD, under Dr. Riley's supervision to treat me with the truSculpt FLEX device. I understand that this procedure works by using electrical stimulation to strengthen, firm and tone the abdomen, buttocks and thighs. There is little or no downtime associated with this treatment. It is possible the result will be minimal or not help at all.

The procedure may result in the following adverse experiences or risks:

- **INCREASED HEART RATE** – This procedure has a risk of increasing patient's heart rate.
- **SKIN IRRITATION / HYPERSENSITIVITY –** Some patient may experience skin irritation or hypersensitivity due to the electrical conductive medium.
- **ALLERGIC SKIN REACTION TO GEL PADS** - May occur under the area where the gel pad is applied.
- **TINGLING/NUMBNESS –** Tingling and/or numbness in the treatment area may occur.
- **DISCOMFORT/PAIN & MUSCLE SORENESS –** Moderate discomfort during treatment is expected. Some discomfort, tenderness and muscle soreness in the treatment area may persist for a few hours following treatment, potentially extending to a few days.
- **BURNS –** Burns beneath the electrodes have been reported with the use of powered muscle stimulators. If this occurs, please call our office for wound management instructions.
- **RANDOM MUSCLE CONTRACTION –** May be experienced after the procedure.
- **FREQUENT URINATION/BOWEL STIMULATION –** May be caused by the procedure.
- **INCREASED HUNGER –** Increase in metabolic rate results in feeling hungry more frequently. Please be aware of this and refrain from overeating post-treatment.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as surgery
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period
- Certain individuals may not be candidates for this procedure (contraindicated) or are at a higher risk for complications. All treatment contraindications, precautions and warnings have been discussed with me.

By signing below I confirm that I do not have a cardiac implant (including defibrillator/pacemaker) nor have I been diagnosed with Myocardial Arrhythmia or Epilepsy. Furthermore, I agree to keep Dr. Riley and staff informed should I have a defibrillator/pacemaker or any cardiac device implanted or be diagnosed with Myocardial Arrhythmia or Epilepsy during the course of treatment. I understand that this procedure should not be performed on patients who have a cardiac implant (including defibrillator/pacemaker) or have been diagnosed with Myocardial Arrhythmia or Epilepsy.

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr. Riley and staff informed should I become pregnant during the course of treatment. I understand that this procedure should not be performed on patients who are pregnant.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR THE TRUSCULPT FLEX PROCEDURE, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

Patient Signature	**Print Name**	**Date**

TruSculpt Flex
PRE & POST CARE

BEFORE YOUR TREATMENT:

- Hair in the treatment and gel pad area may need to be shaved.
- Be well hydrated prior to treatment.
- Body piercings may need to be removed if under or near the treatment area.
- Refrain from alcoholic beverages, caffeine and fatty foods during the treatment regimen.
- Exercise is not recommended on the day of treatment.
- Notify clinic of any changes to your health history or medications since your last appointment.

AFTER YOUR TREATMENT:

- Frequent urination and/or bowel stimulation may be caused by the procedure.
- Tingling in the area/s treated up to a few hours after procedure.
- Slight muscle soreness/tenderness 24-72 hours after procedure.
- Random muscle contraction after procedure.
- Slimming in the area treated for up to 48 hours after procedure.
- Increase in metabolic rate results in feeling hungry more frequently. Please be aware of this fact and DO NOT overeat.
- Burns beneath the electrodes have been reported with the use of powered muscle stimulators. If this occurs, please call our office for wound management instruction.

- Additional instructions:

  _____

  _____

  _____

Clinic: Cornerstone MD

Clinic Phone Number: 469-801-8480

No-Show, Late & Cancellation Policy

Description

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the practice 15 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Our goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message **at least 24 hours** before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Should the patient fail to provide 24-hour notice of cancellation, reschedule or no-show, the patient is subject to a $50 cancellation fee.

Procedure

I. A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. **Established patients:**

a. Appointment must be canceled at least 24 hours prior to the scheduled appointment time.

b. In the event a patient arrives late as defined by "late arrival" to their appointment, and cannot be seen by the provider on the same day, they will be rescheduled for a future visit.

c. In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from the practice. The patient's chart is reviewed and dismissals are determined by a physician only, no exceptions.

III. **New patients:**

a. Appointment must be canceled at least 24 hours prior to scheduled appointment time.

b. In the event of a no-show, the practice may require a new referral sent from the referring physician.

c. In the event a patient arrives late as defined by "late arrival" to their appointment, the practice reserves the right to request a new referral sent from the referring physician.

d. In the event of three (3) documented "no shows" and/or "same-day cancellations," the patient may be subject to dismissal from the practice. The patient's chart is reviewed and dismissals are determined by a physician only, no exceptions.

Patient Printed Name _____

Patient Signature _____ **Date** _____

CornerStoneMD

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatments. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and the treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and other health care providers or the designees as deemed necessary to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Consent for Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. CornerstoneMD respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and text messaging can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. Voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. CornerstoneMD will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

(Check all that apply:)

- ○ I consent to the following forms of communication, including but not limited to communication about my medical condition and advice from my health care providers.
  - ○ Voicemail
  - ○ Email
  - ○ Text Message
- ○ I do not consent to **any** voicemail, email or texting communication.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Signature of Patient or Personal Representative **Date**

_____

Printed Name of Patient or Personal Representative **Relationship to Patient**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

Patient acknowledgement of the Notice of Privacy Practices and Consent for use and disclosure of personal health information.

I, _____, acknowledge that I have received a copy of this office's Notice of Privacy Practices or that this office's Notice of Privacy Practices was made available to me to receive.

I, _____, consent to the use and disclosure of my personal health information by your office for treatment, billing, payment and health care operations as outlined in the Notice of Privacy Practices.

Print Patient's Name Date

Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to CornerstoneMD (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the CornerstoneMD (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider any services rendered at the time of service they will not pay for the service rendered during time of visit. I agree to be fully responsible for payment to CornerstoneMD for this service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge in the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by CornerstoneMD.

Payment Guidelines:

We collect copays, coinsurance, and/or deductibles at the time of service unless other written arrangements have been made in advance with our office. We accept **Cash, Checks and Credit Cards** (Visa, Mastercard, Discover and American Express). If your check is returned, a processing fee will be assessed in addition to the amount of the check.

A claim will be sent to your insurance company for payment. If your insurance company remits the payment to you, please send the payment to our office, along with the Explanation of Benefits. Any balance that your insurance company determines to be your financial responsibility will be mailed to you. Payment is due in full upon receipt of your statement. Balances that remain unpaid after 90 days may be referred to an outside collection agency for further collections efforts.

OUT-OF-NETWORK PROVIDER

I understand and acknowledge that my health insurance plan considers Cornerstone MD/MetTrimMD an out-of-network provider. I am aware that I am responsible for payment at the time of service. I have been told what I will be responsible for and I agree to the pricing. I hereby authorize Cornerstone MD/MetTrimMD to provide me with treatment and care.

PATIENT CONSENT FORM: SELF PAY PROVIDER

I understand and acknowledge that Cornerstone MD/MetTrimMD does not accept my insurance. I am aware that I am responsible for payment at the time of service. I have been told what I will be responsible for and I agree to the pricing. I hereby authorize Cornerstone MD/MetTrimMD to provide me with treatment and care.

I understand and agree this document will remain in effect for all future outpatient or physician office visits to CornerstoneMD, unless specifically rescinded in writing by me.

Patient Signature _____ Date: _____

Relationship to Patient: _____

Photography Consent Form

In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessary to help you fully understand it. Please sign at the bottom only after careful review and consideration.

For your consideration, I, the undersigned, hereby give Cornerstone MD and its clients or agents permission for use of the photographs that they have taken of me.

- (1) To copyright the same in their name or any other name that they may choose.
- (2) To use and publish the same in whole or in part, individually or in conjunction with other photographs, in any medium for any purpose, including art, illustration, promotion, advertising or trade.
- (3) It is understood that the use of the photographs is for illustrating a medical procedure and demonstration of treatment outcomes, including, but not limited to:
    - Photo Book
    - Website or Social Media Sites
    - TV Broadcast
    - Digital/Print Article or Publication
    - Advertisement
- It is also understood that the use of the photographs used by CornerstoneMD or MetTrimMD will be used in a way to protect patient identity, including, but not limited to facial procedures.

I hereby release Cornerstone MD and its agents from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I am of legal age.

I have read the foregoing fully and understand its contents.

Patient Name: _____

Patient Signature: _____

Date: _____

CornerStoneMD

MetTrim MD

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting CornerstoneMD at 469-801-8480.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments, deductibles or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____

Date

Card on File Agreement

CORNERSTONEMD, PLLC

12222 N CENTRAL EXPRESSWAY

DALLAS, TX, 75243

469-801-8480

Terms

Maximum charge amount: $1,500.00

Effective date: Date of Signature

Expiration date: One year from Effective Date

I agree to allow CORNERSTONEMD, PLLC to charge the card on file for any amount not covered by insurance (up to the maximum charge amount), for all services provided by CORNERSTONEMD, PLLC to the patient(s) on or after the effective date and before the expiration date.

I acknowledge that:

- My credit card will be charged upon review of the final explanation of benefits from each applicable insurance company for services provided while this agreement is in effect.
- Once a total of $1,500.00 has been charged to my credit card under this agreement, CORNERSTONEMD, PLLC will bill me directly for any amounts not covered by insurance.
- My credit card will be stored by QuickBooks and/or Elavon, Inc., secure credit card processors that partner with CORNERSTONEMD, PLLC to collect payments.
- I will receive receipts detailing the amount charged.

I may cancel this agreement at any time by contacting CORNERSTONEMD, PLLC; any unpaid amounts relating to services provided while this agreement is in effect that are not covered by insurance will then be billed to me directly.

Printed Name: _____

Signature: _____

Date: _____

(merchant copy)