

# 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		
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## 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?

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## Current Medications

What medications are you currently taking?

Name	Dosage	Frequency
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

## Allergies

Do you have any medication, food or environmental allergies?

Name	Reaction
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

## Past Medical History

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

## Hospitalizations & Surgeries

Reason <hr/>	Date <hr/>
Reason <hr/>	Date <hr/>

## Family History (Only Relatives)

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

<input type="checkbox"/> Bleeding Disorder	<hr/>
<input type="checkbox"/> Cancer	<hr/>
<input type="checkbox"/> Diabetes	<hr/>
<input type="checkbox"/> Heart Disease	<hr/>
<input type="checkbox"/> High Cholesterol	<hr/>
<input type="checkbox"/> High Blood Pressure	<hr/>
<input type="checkbox"/> Psychiatric Disorders	<hr/>
<input type="checkbox"/> Stroke	<hr/>

Details:

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## Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year 

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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 

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 # packs/day 

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Do you smoke now?

☐ Yes ☐ No # packs/day 

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Do you use recreational drugs?

☐ Yes ☐ No types? 

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 # times/week 

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How much alcohol do you drink per week?

# drinks/week 

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How much caffeine do you drink per day?

# drinks/day 

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How often do you exercise?

# times/week 

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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 pregnancies you have had.

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

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

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?

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?

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
<input type="checkbox"/> Colonoscopy		
<input type="checkbox"/> Dexascan (Bone Density)		
<input type="checkbox"/> Fecal Occult Blood Test		
<input type="checkbox"/> Flu Vaccine		
<input type="checkbox"/> HPV Vaccine		
<input type="checkbox"/> Mammogram		
<input type="checkbox"/> Pap Smear		
<input type="checkbox"/> 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

# DOES CANCER RUN IN YOUR FAMILY?

Your healthcare provider needs to know for your visit today!

**TAKE A PICTURE WITH YOUR  
CAMERA TO OPEN!**



1

Use your phone to access our screening site

[www.mygenehistory.com/cornerstonemd](http://www.mygenehistory.com/cornerstonemd)



2

Enter your personal and family cancer history

Don't forget your grandparents, aunts, uncles and cousins on both sides!



3

Show your result to your healthcare provider

If your result meets society guidelines, watch the included video. This video will answer many of the questions you may have.

**Myriad myRisk™ Hereditary Cancer testing  
may be an option for you today.**

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

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

Today's Date: \_\_\_\_\_

**Check the box based on the result you receive:**

- ☐ Based on your answers, you appear to meet society guidelines for hereditary cancer testing. You may be a candidate for Myriad myRisk™ Hereditary Cancer testing. Please make sure to discuss your results with your provider.
- ☐ Based on your answers, you do not appear to meet guidelines for hereditary cancer testing. However, it is still important to discuss your personal and family history with your healthcare provider.



## Specialty Care Screening

**Patient Name:** \_\_\_\_\_

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

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CornerStoneMD

## Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Today's Date: \_\_\_\_\_

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

### My birth control method is: (please circle)

Abstinence      Birth control pill      Hysterectomy      IUD      Menopause      Tubal ligation      Vasectomy      Other

**CONSENT FOR TREATMENT:** I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

**BENEFITS OF TESTOSTERONE PELLETS INCLUDE:** Increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

Print Name

Signature

Today's Date



### Post-Insertion Instructions for Women

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. It **must** be removed as soon as it gets wet. The inner layer is either waterproof foam tape or steri-strips. They should be removed in **3 days**.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours.
- Do not take tub baths or get into a hot tub or swimming pool for **3 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next **3 days**, this includes running, elliptical, squats, lunges, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg. orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

#### Reminders:

- Remember to go for your post-insertion blood work **6 weeks** after the insertion.
- Most women will need re-insertions of their pellets **3-4 months** after their initial insertion.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. The charge for the second visit will only be for the insertion and not a consultation.

#### Additional Instructions:

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I acknowledge that I have received a copy and understand the instructions on this form.



Print Name

Signature

Today's Date



## WHAT MIGHT OCCUR AFTER A PELLET INSERTION

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- **FLUID RETENTION:** Testosterone stimulates the muscle to grow and retain water, which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.
- **SWELLING OF THE HANDS & FEET:** This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.
- **UTERINE SPOTTING/BLEEDING:** This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.
- **MOOD SWINGS/IRRITABILITY:** These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.
- **FACIAL BREAKOUT:** Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.
- **HAIR LOSS:** Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.
- **HAIR GROWTH:** Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

I acknowledge that I have received a copy and understand the instructions on this form.

\_\_\_\_\_  
Print Name



\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date





CornerStoneMD

## Mammogram Waiver for Testosterone and/or Estradiol Pellet Therapy

I, \_\_\_\_\_, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone and/or estradiol pellet therapy, even though I am not current on my yearly mammogram. I understand that such therapy is controversial and that many doctors believe that estradiol replacement in my case is contraindicated. My Treating Provider has informed me it is possible that taking estradiol could possibly cause cancer, or stimulate existing breast cancer (including one that has not yet been detected). Accordingly, I am aware that breast cancer or other cancer could develop while on pellet therapy.

**For today's appointment I DO NOT have a mammogram for the following reason:**

☐ **My decision not to have one.**

☐ **Unable to provide the report at this time.**

☐ **My doctor's decision not to have one.** Please provide a note from your treating physician with their rationale as to why they don't want you to have a mammogram.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive testosterone and/or estradiol. \_\_\_\_\_ (initials of patient)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast, uterine or cancer issues) that may be sustained by me in connection with my decision to not have a mammogram and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives

\_\_\_\_\_  
Patient Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Provider Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

## 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** \_\_\_\_\_



## 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.**

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**Signature of Patient or Personal Representative**

**Date**

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**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.**

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## 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).

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## 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.

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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: \_\_\_\_\_



## 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).

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Patient/Parent/Guardian Printed Name

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Patient/Parent/Guardian Signature

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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)***



## **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: \_\_\_\_\_