CORNERSTONE FAMILY MEDICINE

Chad A. Griffin, MD Anna Benningfield, APN Kelly Lyons, APN

Name: _____ **Date:** _____

Address: _____ **City:** _____ **ST**_____ **Zip**_____

Home Phone: _____ **Work:** _____ **Cell:** _____

DOB: _____ **SSN:** _____-_____-_____ **Marital Status:** () M () S () W () D

Sex: Male / Female **Race:** White / Black / Asian / Bi-racial **Primary Language:** _____

Ethnicity: Hispanic / Non-Hispanic

Email Address: _____

PARENT INFORMATION: (If under age of 18)

Mothers Name: _____ DOB:_____ SSN: _____

Fathers Name: _____ DOB: _____ SSN: _____

IF INSURANCE DOES NOT PAY COMPLETELY, PERSON RESPONSIBLE FOR BALANCE

Name: _____SSN: _____ DOB: _____

Address: _____ Phone: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name: _____ Relationship: _____ Phone: _____

Authorizations

I understand that I am financially responsible for services rendered by the physician and his staff regardless of insurance, including reasonable attorney's fees and costs of collection in the event of default. I authorize my insurance company to pay benefits directly to Cornerstone Family Medicine, LLC or my physician. I hereby authorize the release of information concerning my medical records, including the diagnosis and records of any treatment, laboratory test, or examinations, Photostat or faxed to Cornerstone Family Medicine, LLC or my physician to nay agency requiring records for processing Medicare, Tenncare and insurance claims. IF APPLICABLE: I give consent for the above patient, who is either under the age of 18 or requires legal custodian, to receive any treatment that is deemed necessary by Cornerstone Family Medicine, LLC. I understand all of the above and herby state that the information is correct to the best of my knowledge. These authorizations apply to all occasions until revoked. My signature indicates that I have read the above and grant to request of authorizations.

Signature: _____ **Date:** _____

Cornerstone Family Medicine, LLC
433 Sewell Rd
Sparta, TN 38583
Phone: 931-739-3000 Fax: 931-739-3013

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Anna Benningfield, APN
Kelly Lyons, APN

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the use of disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may by subject to redisclosure and no longer protected by the federal privacy regulations.

PATIENT NAME: _____ **DOB:** _____

Physician to Release Records:

_____
_____
_____

Information Sent To:
Cornerstone Family Medicine
433 Sewell Rd
Sparta, TN 38583

INFORMATION TO BE RELEASED: (PLEASE SPECIFIY ONE)

1. **ALL RECORDS GENERATED BY THIS FACILITY:** _____
2. **ALL ABOVE INFORMATION EXCEPT:** Substance Abuse ____, Mental Health ____, AIDS/HIV _____, Other _____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure if information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for the disclosure of information created for the sole purpose of disclosure to a third party, any result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

Patient's initials _____

A copy of this form will be provided if requested. Cornerstone Family Medicine will not receive financial or in kind compensation in exchange for using or disclosing the health information described above. Expiration or revocation of authorization. I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

PATIENT NAME (PRINT) _____

PATIENT SIGNATURE _____

DATE _____

Cornerstone Family Medicine, LLC

IMPORTANT NOTE TO PATIENTS

PLEASE READ

The new HIPAA Law protects your right to privacy. We can't provide any information to family and/or friends about you or your health status (i.e. test results, xrays, surgeries, office visits, etc) unless you give us written permission. Without your authorization, we can only provide your health information to those listed in the **Notice of Privacy Practices.** If you would like for relatives, friends or other individuals to have access to your information (health status, test results, etc) a **signed** release form **must** be completed. By completing the attached form you are authorizing Cornerstone Family Medicine, LLC to provide your health information (per your instructions) to those you have listed. You have the right to revoke this release at any time by notifying our medical records department. If you have any questions you may ask the nurse or contact the HIPAA Privacy Officer.

To Whom May We Release Your Records: (Ex: Spouse, Children, Parents or Guardian)

1. _____
2. _____
3. _____
4. _____
5. _____

PATIENT/PARENT SIGNATURE: _____

DOB: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Cornerstone Family Medicine's ***Notice of Privacy Practice*** containing a description of the uses and disclosures of my health information. I further understand that Cornerstone Family Medicine may update its ***Notice of Privacy Practices*** at any time and that I may receive an updated copy of Cornerstone Family Medicine's ***Notice of Privacy Practices*** by submitting a request in writing for a current copy of Cornerstone Family Medicine's ***Notice of Privacy Practices.***

Print Name: _____

Signature: _____ **Date:** _____

If completed by patient's personal representative, please print name and sign below.

Representative Name: _____ **Relationship to Patient** _____

Representative Signature: _____ **Date:** _____

For Cornerstone Family Medicine Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Cornerstone Family Medicine made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below.

[] Patient or patient's personal representative refused to sign

[] Patient or patient's personal representative unable to sign

[] Other

Employee Signature _____ Date _____

CORNERSTONE FAMILY MEDICINE

Acknowledgement of Living Wills and Durable Power of Attorney

I have received a copy of the Living Will and Durable Power of Attorney for Health Care paperwork. I understand this is for information purposes only, if I wish to execute a Living Will or a Durable Power of Attorney I can contact an attorney to help me in this matter.

_____ **If you have a living will** please initial here. (We would like a copy for your chart)

_____ **I would** like information regarding a living will.

_____ **If you decline** a living will please initial here.

Signature: _____ **Date:** _____

Medicare Shared Savings Program
Accountable Care Organizations

Cornerstone Family Medicine participating in Cumberland Center for Healthcare Innovation, an Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and/or other health care providers that work together to improve the quality and experience of care you receive. ACOs receive a portion of any savings that result from reducing costs and meeting quality requirements.

- Medicare evaluates how well each ACO meets these goals every year. Those ACOs that do a good job can earn a financial bonus. ACOs that earn a bonus may use the payment to invest more in your care or share a portion directly with your providers. ACOs may owe a penalty if their care increases costs.
- Cornerstone Family Med. participation in Cumberland Center for Healthcare Innovation doesn't limit your choice of health care providers. Your Medicare benefits are not changing. You still have the right to visit any doctor, hospital, or other provider that accepts Medicare at any time, just like you do now.
- To help us coordinate your health care better, Medicare shares information about your care with your providers. If you don't want Medicare to share your health care information, call 1-800-MEDICARE (1-800-633-4227).

? How do ACOs work?

- An ACO **isn't** a Medicare Advantage plan which is an "all in one" alternative to Original Medicare, offered by private companies approved by Medicare. An ACO **isn't** an HMO plan, or an insurance plan of any kind.

Important!

- ACOs have agreements with Medicare to be financially accountable for the quality, cost, and experience of care you receive.
- Coordinated care can avoid wasted time and costs for repeated tests and unneeded appointments. It may make it easier to spot potential problems before they become more serious – like drug interactions that can happen if one doctor isn't aware of what another has prescribed.
- ACOs may use electronic health records, case managers, and electronic prescriptions to help you stay healthy. Some ACOs have special programs to encourage you to have a primary care visit or use their care management team. Participation in these programs is optional.

? What information will be shared about me?

- Medicare shares information about your care with your health care providers; like dates and times you visited a health care provider, your medical conditions, and a list of past and current prescriptions. This information helps Cumberland Center for Healthcare Innovation track the care and tests that you've already had.
- Sharing your data helps make sure all the providers involved in your care have access to your health information when and where they need it.
- **We value your privacy**. ACOs must put important safeguards in place to make sure all your health care information is safe. We respect your choice on how your health care information is used for care coordination and quality improvement. If you want Medicare to share your health care information with Cumberland Center for Healthcare Innovation or other ACOs in which your health care providers participate, there's nothing more you need to do.

- If you **don't** want Medicare to share your health care information, **call 1-800-MEDICARE** (1-800-633-4227). Tell the representative that your health care provider is part of an ACO and you don't want Medicare to share your health care information. TTY users should call 1-877-486-2048.
- If you change your mind and want to let Medicare share your health information again, call 1-800-MEDICARE to let Medicare know. We aren't allowed to tell Medicare for you.
- Even if you decline to share your health care information, Medicare will still use your information for some purposes, like assessing the financial and quality of care performance of the health care providers participating in ACOs. Also, Medicare may share some of your health care information with ACOs when measuring the quality of care given by health care providers participating in those ACOs.

How can I make the most of getting care from an ACO?

- Ask your clinician if they have a secure online portal that gives you 24-hour access to your personal health information, including lab results and provider recommendations. This will help you make informed decisions about your health care, track your treatment, and monitor your health outcomes.
- As a Medicare beneficiary, you can choose or change your primary clinician or "main doctor" at any time. Your primary clinician is the health care provider that you believe is responsible for coordinating your overall care. If you choose a primary clinician, that clinician may have more tools or services to help with your care. You can learn more in the Voluntary Alignment Beneficiary Fact Sheet.

For step-by-step instructions on how to select or change your "main doctor," refer to the Choosing a Primary Clinician video (https://youtu.be/JHPxtKftSTA).

What if I have concerns about being part of an ACO?

- If you have concerns about the quality of care or other services you receive from your ACO or provider, you can contact your Medicare Beneficiary Ombudsman who can assist you with Medicare-related questions, concerns, and challenges. The Medicare Beneficiary Ombudsman works closely with the Medicare program, including Medicare.gov, 1-800-MEDICARE, and State Health Insurance Assistance Programs (SHIPs), to help make sure information and assistance are available for you. Visit Medicare.gov for information on how the Medicare Beneficiary Ombudsman can help you.
- If you suspect Medicare fraud or abuse from your ACO or any Medicare provider, we encourage you to make a report by contacting the HHS Office of Inspector General (1-800-HHS-TIPS) or your local Senior Medicare Patrol (SMP).

I have read and reviewed the above information.

Patient Name (Print)

Patient Signature

Date

ONE–TIME AUTHORIZATION

(ANYONE WITH MEDICARE)

I request that payment of authorized Medicare benefits be made on my behalf to Cornerstone Family Medicine, LLC (Dr. Chad Griffin) for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Date: _____

Signature: _____