Cornerstone Physical Therapy & Wellness

Patient Information

Date _____ Soc. Sec. # _____ Age:_____ Birthdate _____

Name _____ Home Phone _____

Last Name First Name Middle Initial

Address _____ Apt #_____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex □ M □ F □Minor □Single □Married □Long Term Partner □Divorced □Widowed □Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Insurance

Person Responsible for Account: _____

Relationship to Patient: _____ Birthdate: _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Cancellation Policy

Please note that maintaining therapy appointments is necessary for your recovery. In this day and age of Managed Care, insurance companies limit the number of visits and/or the length of time a patient may receive physical therapy. When you miss an appointment you are not only impeding your progress but you may be losing a visit from your insurance benefit. **We have a 24 hour cancellation policy** on all appointments. If you are unable to keep your scheduled appointment, we would appreciate notification so another patient may utilize your cancellation spot. **Failure to submit proper notification will result in a personal charge of $50.00**.

Thank you.

Assignment and Release

I hereby authorize payment directly to Cornerstone Physical Therapy & Wellness, PLLC of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature_____ Date _____

Consent

I will provide an accurate history of my illness and past medical conditions to Cornerstone Physical Therapy & Wellness, PLLC and consent to the treatment rendered. If I have any questions or concerns about any technique I will ask my therapist. I have the right to refuse any treatment I feel is not appropriate and will express these concerns with my therapist.

Patient Signature _____ Date _____