277 Blair Park Rd
Suite 110
Williston, VT 05495

Cornerstone Welcomes You

Patient Name: ____

Address: (**Not PO Box or RR**) ____

Mailing Address: ____

City: _______________________________ State: ________________ Zip: ____________________________

Home Phone (____) _______________ Work Phone (____) ____________ Cell Phone (____)______________

DOB: ___________ Sex: F M Marital Status: _____________ Student: Yes No

Social Security #: ___________________ E-mail Address____

Is this visit a result of an accident? Yes No (If yes) Date of Injury: _______________________________
Type of accident: (please circle) Workers' Compensation? Auto? Other?

Have you had any other PT, OT, Chiropractic or Speech Therapy this current year? _____________________
If yes, how many visits were you seen? ____

Referring Physician: ____
(Include name and address)

Primary Care Physician: ____
(Include name and address)

Patient Employer: ____
Employer Address: ____
Supervisor: ____

Spouse or Parent: ____
Billing Address: ____
Phone Number: ____

How would you like reminders for your Cornerstone Appointments?
**Please Circle One of the Options Below: (if phone call, please indicate the best number)
Email Phone Call Text Message I Don't Need a Reminder

<u>Authorization and assignment of benefits</u>
By my signature below, I give my permission to be treated by Cornerstone Physical Therapy, for the above named patient. I further authorize Cornerstone Physical Therapy to bill my Insurance Company and for payment to be made directly to Cornerstone Physical Therapy for service rendered on my behalf. I also authorize the release of medical documentation needed by any parties involved in the processing of my claim. I also accept responsibility for all charges incurred as a result of the medical treatment I receive.

____ Date: ________________________
(Signature of Patient, If minor Signature of Parent or Guardian)

Cancellation Policy **(Effective January 1st, 2012)**
Because we offer one-on-one patient care and reserve time specifically for you, we have a 24 hour cancellation policy. Failure to show or cancel within 24 hours of your scheduled appointment will result in a $30 charge billed to you. Thank you for understanding.

___ Patient Initials

Medical Release
I authorize Cornerstone Physical Therapy to release information from my medical records to insurance companies and their agents for the purpose of determining my medical benefits and for any benefits payable for related services.

I authorize Cornerstone Physical Therapy to release and receive medical records between primary care and/or referral physicians and other medical specialists, including personal trainers, for the purpose of coordinating treatment.

I authorize Cornerstone Physical Therapy to release medical records to another party. Please list appropriate party only if needed:____

Signature________________________________ Date______________________

Insurance Information

*Please present a valid insurance card to the front desk upon arrival.

*If you have an auto / workers compensation claim, please fill out the following information:

Claim Type (Circle one): Automobile Accident Worker's Compensation

Insurance Company:____
Claim #:____
Date of Injury:____
Address to send bills:____
City:__________________________State:_______Zip:______________________
Claim Adjuster's Name:____
Adjuster's Telephone Number:______________________________________