5300 Westview Drive, Suite 108
Frederick, MD 21703
Phone: (301) 732-4754   Facsimile: (301) 732-5702
Visit us on the web at: www.cornerstonept.net

Thank you for choosing Cornerstone Physical Therapy for your therapy needs. Our mission is to provide our patients with the highest level of care, to provide the best therapeutic interventions and to assist them in their journey toward optimal health and function. Welcome to our office!

General Information

So that we have a mutual understanding concerning your treatment, we ask that you review the following information prior to starting your program and sign the acknowledgment form on the next page.

APPOINTMENTS – We ask that you make every effort to keep your appointments and to arrive by your scheduled time. If you arrive more than fifteen minutes late for an appointment we cannot guarantee that you will be seen that day. Please help us to serve you (and all of our patients) better by keeping your scheduled appointments.

CANCELLATION POLICY – There will be a fee of $40.00 for failure to keep a scheduled appointment or provide a minimum of 24-hour notice for appointment cancellation. You may contact our office anytime and leave a message or via e-mail at **info@cornerstonept.net**

APPOINTMENT REMINDERS – We send appointment reminders either via e-mail or text messaging, whichever you prefer, 24 hours prior to your scheduled time. For some phone carriers a text message rate may apply. Please indicate your preference on the next page. This convenient service will start with your next scheduled appointment time.

CLOTHING – Please wear loose and comfortable clothing for each session.

PAYMENT – We may use or disclose your health information to obtain payment for services we provide to you. You are responsible for all payment of services rendered by Cornerstone Physical Therapy whether your insurance company pays or not. Although we will do our utmost to assist in gathering information regarding claims payment, it is your responsibility to know your benefit coverage limits as well as which services require authorization. Payment is due at the time of service for co-pays, co-insurance, deductibles and services deemed non-covered by your insurer and any other items addressed herein. We accept cash, Visa, MasterCard and personal check.

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Acknowledgement of General Information Form/Appointment Reminder Selection

I, ____, acknowledge I have received and reviewed the General Information Sheet which includes the fee for failure to keep a scheduled appointment or provide 24 hour notice for cancellation. I understand the monetary obligation on my part if I fail to notify the office of appointment cancellation.

My preferred method of appointment reminder is: (please choose one)

□ E-mail: (please provide address) ____

□ Text message: (please provide phone number) ____

We cannot set up your account for text message without knowing your cell phone carrier. Please indicate your carrier below:

- □ ALLTel
- □ AT&T
- □ Boost Mobile
- □ Cingular
- □ Cricket Wireless
- □ Metrocall
- □ MetroPCS
- □ Nextel
- □ Qwest
- □ Sprint PCS
- □ T Mobile
- □ US Cellular
- □ Verizon
- □ Virgin Mobile

____

Signature of patient or Parent/Guardian of patient

____

Date

***** please note – text messaging rates may apply depending on your carrier***