



5350 Partners Court, Suite B Frederick, MD 21703 Phone: (301) 732-4754 Fax: (301) 732-5702
www.Cornerstonept.net info@cornerstonept.net

General Information

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 each patient in their journey toward optimal health and function. Welcome to our office!

To ensure a mutual understanding regarding your treatment and our office policies, please review the information below prior to starting your program and sign the acknowledgment document.

APPOINTMENTS — We ask that you make every effort to keep your appointments and to arrive by your scheduled time. We send appointment reminders via e-mail or text messaging 24 hours prior to your scheduled time, beginning with your next scheduled appointment time. If you arrive more than fifteen minutes late for an appointment, we cannot guarantee that you will be seen that day. Missed appointments limit our ability to provide care to other patients who may need that time.

CANCELLATION POLICY— If you are unable to keep your appointment, we kindly ask that you notify us at least 24 hours in advance. This allows us to offer the appointment time to another patient. There will be a fee of \$80.00 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

SCHEDULING— Cornerstone offers a variety of treatments and services. As such, our schedule fills up quickly. We do our best to ensure every patient receives the quality care they need. Please be aware that we may hold open spaces in the schedule for a variety of circumstances.

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

PAYMENT— Payment is due at the time of service. This includes co-pays, co-insurance, deductibles and services deemed non-covered by your insurer and any other items addressed herein. We accept cash, Visa, MasterCard, Discover, American Express, and personal check. Whether your insurance company pays or not, you are responsible for all payment of services rendered by Cornerstone Physical Therapy. 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. In accordance with HIPAA rules, we may disclose your health information to your insurance company in order to obtain payment for services we provide to you.

CREDIT CARD ON FILE AUTHORIZATION — To streamline our check-in and payment processes, Cornerstone can securely store your credit card on file to process any applicable fees, including:

- Missed or late cancelled appointments
- Outstanding balances, not paid at the time of service
- Other charges incurred in accordance with practice policies

COMMUNICATION

We may send periodic informative and/or promotional emails. You will have the opportunity to opt out of future emails in these communications. Please know, we do not sell or share your personal information.



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Acknowledgement of General Information Form/Appointment Reminder Selection

I, _____, acknowledge that I have reviewed and agree to abide by the General Information Sheet and all information contained therein.

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

Text message**: (please provide phone number) _____

OR

E-mail: (please provide e-mail address) _____

Credit Card Authorization: (please choose ONE)

I authorize Cornerstone Physical Therapy to securely store my credit card on file. I understand and agree that this card may be charged applicable fees, including but not limited to:

OR

- Missed or late cancelled appointments
- Outstanding balances, not paid at the time of service
- Other charges incurred in accordance with practice policies

I do not authorize Cornerstone Physical Therapy to store my credit card on file. I understand that I will be liable to pay for each visit at the agreed upon rates at the time of service along with any applicable fees or outstanding balances.

We value your privacy and security. Therefore, your credit card information will be kept confidential and encrypted. I understand that I may update or revoke this authorization in writing at any time.

Signature of Patient or Parent/Guardian

Print Name of Parent/Guardian

Print Name of Patient(s)

Date

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