CORNERSTONE THERAPY ASSOCIATES

12371 Cottage Woods Drive
Ashland, VA 23005
804.363.7214 804.442.7027 (fax)

New Patient Information Form

Child's Name: First_____ Last_____ Middle Initial_____

Child's Date of Birth _____ Male_____ Female_____

Child's Primary Care Physician Name_____ Phone_____

Diagnosis of your child_____ Physician's Name/Phone_____

Parent or Guardian Name: First_____ Last_____ Middle Initial_____

Parent or Guardian Name: First_____ Last_____ Middle Initial_____

Street Address _____ Home Phone_____

City, State, Zip _____ Cell Phone_____

Email_____

Person Responsible for Bill_____

Street Address (if different from above)_____

City, State, Zip_____

Occupation_____ Employer_____ Work Phone_____

Primary Insurance _____ Policyholder Name_____ Date of Birth_____

ID Number_____ Group Number_____

Insurance Phone Number_____ Card Date_____

Secondary Insurance (if applicable)_____

ID Number_____ Group Number_____

Insurance Phone Number_____ Card Date_____

Chose Cornerstone Because/Referred by_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. **Payments are due within 30 days of receipt of invoice**. I also authorize Cornerstone and/or my insurance company to release any information required to process my claims. This form also authorizes Cornerstone to treat my child as needed based on evaluations and therapist recommendations.

Signature_____ Date_____