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_____

Chose Cornerstone Because/Referred by_____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. Payments are due within 14 days of receipt of invoice. This form also authorizes Cornerstone to treat my child as needed based on evaluations and therapist recommendations.

Signature_____ Date_____