



33E Kennedy Road Po Box 106
Tranquility, NJ. 07879
Phone: (908) 684-1241
Fax: (908) 684-4039

77 Brant Avenue Suite 101
Clark, NJ. 07066
Phone: (732) 499-4540
Fax: (732) 499-4577

1323A Route 34
Aberdeen, NJ 07747
Phone: (732) 290-1080
Fax: (732) 290-1082

CONSENT TO TREAT

I, _____ authorize Cornerstone Physical Therapy Inc. to administer all necessary treatments and care required for my rehabilitation.

Patient Signature

Witness Signature

Print Name

Print Name

CANCELLATION AND NO SHOW POLICY

Date: _____

To ensure fairness to all of our patients and respect the time set aside for you and your therapist, **our policy is that we require a twenty-four hour notice for all cancellations. Failure to give adequate notice will result in a \$35 charge, which is not covered by your insurance. Failure to show for an appointment without any notice will also result in a \$35 charge, which is not covered by your insurance.** If the patient no shows three times during the course of their treatment sessions, the physical therapist reserves the right to either discharge the patient, or restrict the times the patient may schedule further appointments.

I, _____ understand and agree to the terms stated above and understand that failure to abide by the cancellation and no show policy will result in a charge that is my responsibility.

Patient Signature

Witness Signature

Print Name

Print Name