Momentum Physical Therapy

INTAKE FORM

Date: ____/_____/20____
Name: _____
Address: _____
E-Mail: _____
Home: (_____) _____ - _____ Cell: (_____) _____ - _____
Employer:_____ Work: (_____) _____ - _____
SSN: _____ - _____ - _____
Date of Birth: ____ / _____ / _____
Alias: _____
Emergency Contact: _____ Emergency Contact Phone:
_____ (_____) _____ - _____

INSURANCE

Insured Name (If different from the patient): _____
Insured's SSN _____ - _____ - _____ Insured Date of Birth: ____ / ____ / _____
Patient Insurance ID#: _____ Relationship to Insured: _____
Group ID (if applicable): _____ Group Name (if applicable):_____

Health Insurance Carrier:
Address: _____
Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
Primary Care Physician (name, phone, fax): Referring Physician (name, phone, fax):
_____ _____
_____ _____
How did you hear about us? Word of Mouth (Name?), Doctor, Website, Facebook, Sign, Newspaper, Phonebook, Other
_____

*A **copy** of your **insurance card** and **prescription** will be added to your file at your first visit.

*Please be familiar with your insurance's **Physical Therapy Benefits** (i.e. Copay, Deductible, Plan Type) prior to your first visit.

***Please call your Primary Care Physician for a **Referral** (if required by your plan) and **Prescription** prior to your first visit.

Momentum NPI #: 1265674105 **Momentum Fax**: 508.422.0102

Momentum Physical Therapy

Informed Consent for Physical Therapy Treatment

I voluntarily give consent and permission for **Momentum Physical Therapy, Inc.** and its licensed physical therapists to administer medically necessary physical therapy services. I am aware that a physician may refer me to physical therapy or I may seek one out on my own because of Direct Access in the Commonwealth of Massachusetts. I acknowledge that physical therapy is not an exact science and that there are no guarantees for treatment success. It is the intent of **Momentum Physical Therapy, Inc.** to provide education regarding patient rights and clinic policies to every patient. This consent shall be ongoing for a period not to exceed 1 year.

Signature: _____ Date: _____

Release of Medical Information

I hereby authorize **Momentum Physical Therapy, Inc.** to obtain any and all medical records needed to aid my evaluation and treatment in physical therapy. I further give consent to release any medical information and bills to necessary third parties for the purpose of review, case record, and payment.

Signature: _____ Date: _____

Assignment of Benefits

I hereby authorize my insurance benefits be paid directly to **Momentum Physical Therapy, Inc.** for services rendered. I understand that I am financially responsible for non-covered services and any sums not collected from my insurance company. I acknowledge that if **Momentum Physical Therapy, Inc**. does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays.

All of the information provided is correct and true to the best of my knowledge.

Signature: _____ Date: _____

Momentum Physical Therapy

Cancellation/No-Show policy

I understand and agree that Momentum Physical Therapy has a cancellation / no-show policy in place to protect my time and the time of the other patients and staff associated with Momentum PT.

I am aware that I will be charged a $50.00 fee in the event that I choose to not attend a scheduled appointment, cancel and / or reschedule in less than a 24-hour period from my scheduled visit (weather excluded). Personal Training clients will be charged the cost of one full session.

Out of mutual respect, Momentum Physical Therapy will make every effort to provide a 24-hour notice to the patient for any appointment times that need to be rescheduled or cancelled due to unforeseen circumstances.

We feel that compliance with your appointment times is the most effective way to achieve a timely and complete recovery from your current symptoms.

Thank you,

The Momentum Team

Patient Signature: _____ **Date: _____**

Primary Physical Therapist Signature: _____ **Date: _____**

**A copy of this signed document will be handed to each patient.*

Momentum Physical Therapy

HIPAA Acknowledgement Form

I (print name) _____ hereby acknowledge that I have received a copy of the Momentum Physical Therapy Notice of Privacy Practices (the Notice).

See HIPAA - Notice of Privacy Practices

I understand that the Notice describes how Momentum Physical Therapy uses and discloses my medical and billing information. The Notice also describes my rights and how I can receive additional information.

I have chosen to read the Notice while at Momentum Physical Therapy. I have opted not to take a copy of the Notice with me.

Signature: _____ Date: _____

Printed Name: _____

I have opted to take a copy of the Notice of Privacy Practices home with me to read at my leisure.

Signature: _____ Date: _____

Printed Name: _____

Acknowledgement was obtained by:

Name: _____ Date: _____

Momentum Physical Therapy

Medical and Injury History Form

Patient Name: _____ Date: _____

Thank you for taking the time to fill out this short form. Completing this form will allow your physical therapist to spend more time evaluating your injury.

1. Have you had physical therapy within the last year? Yes No

If Yes, how many visits did you attend? _____ Date of Prior PT:_____

2. Please describe in detail your current injury description? (was this injury work or motor-vehicle related?)

3. Have you had any prior injuries to your body? Yes No

If yes, describe date of injury and treatment course (i.e. PT, Doctor's visit, Medication, Chiro.)

4. Please describe any history of surgery? (include type of surgery, date, surgeon's name, etc.)

5. Please describe your medical history? (i.e. Osteoporosis, Heart Disease, Diabetes, Cancer, etc.)

6. Please list any medication that you are currently taking? (include reason for taking med.)