Momentum Physical Therapy, PLLC
At Lake Manassas

7915 Lake Manassas Drive, Suite 305, Gainesville, VA 20155
8100 Ashton Avenue, Suite 209, Manassas, VA 20109

PATIENT INFORMATION *(please print clearly)*

Name: ______________________ Social Security #: __________
DOB: __________ Age: ______ Gender: ☐ Male ☐ Female Marital Status: __________
Address: ______________________
City: ______________________ State: __________ Zip: __________
Home: Work: Cell:

Referring MD: __________ Description of problem: __________
Is your injury the result of: ☐ Workers Comp ☐ Auto Accident ☐ Other Date of Injury: __________ State: ______
Appointment Reminders: ☐ Text OR ☐ E-mail:

Emergency Contact: __________ Relationship: __________
Phone #: Alternate Phone #:

Patient's Employer: __________ Occupation: __________
Work Status: ☐ Full-time ☐ Part-time ☐ Leave of Absence ☐ Not Employed Are you a student? ☐ Yes ☐ No

Primary Insurance: __________ Employer: __________
Subscriber: Relationship: SS#: DOB:

Secondary Insurance: __________ Employer: __________
Subscriber: Relationship: SS#: DOB:

Worker's Comp (if applicable)
Insurance Carrier: __________ Contact / Ph#: __________
Claim #: Address:

CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I understand that this information is necessary to provide me with rehabilitation treatment in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have Momentum Physical Therapy, PLLC provide treatment and care as prescribed by my physician and/or recommended by my therapist.
I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information to my insurance carrier in order to determine benefits to which I may be entitled.

PATIENT AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize Momentum Physical Therapy, PLLC to apply for benefits on my behalf for services rendered by them, and request payment from my insurance carrier be made directly to Momentum Physical Therapy, PLLC.
Either my insurance carrier or I may revoke this authorization at any time in writing. I permit a copy of this authorization to be used in place of the original.

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

The services you have elected to participate in imply a financial responsibility on your part. You are responsible for payment of your deductible and co-payment / co-insurance as determined by your contract with your insurance carrier. All co-payments must be paid at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved time period, you will be responsible for your account balance in full. ***You are responsible for any amounts not covered by your insurer.***
DELINQUENT ACCOUNTS: Should your account become delinquent, you will be responsible for all collection costs and 28 percent of the principal amounts in collections cost/attorney fees.
RETURNED CHECK FEE: I, the undersigned, agree to pay a fee of $36.00 for any check returned by my financial institution regardless of reason.
REFERRALS / AUTHORIZATIONS: Some managed care plans require written authorization forms from your primary care physician for each visit to a specialist. It is the patient's responsibility to make sure that Momentum Physical Therapy, PLLC has a valid authorization form before each visit. These forms cannot be issued retroactively. Failure to obtain authorization may drastically reduce your benefits/coverage with your insurance carrier.
APPOINTMENTS: All appointments should be scheduled in advance and 24 hour notice is required for cancellations. Patients who are more than ten (10) minutes late for a scheduled visit may not be seen depending on the discretion of the therapist. The patient may be rescheduled for a future visit if not seen. ***There is a $30 fee charged for all NO SHOW / NO CALL visits as well as SAME DAY CANCELLATIONS.***

I certify that I have read the above policies (i.e., Consent to Treatment and Authorization to Release Information; Patient Authorization for Direct Payment; and Statement of Financial Responsibility) and herby give consent to each.
I understand that I may request a copy of this agreement at any time.

Signature: ______________________ Date: __________
Printed Name: