Momentum Physical Therapy

Disclaimer: All information collected about new clients is confidential and will be treated accordingly.

PATIENT INFORMATION (Please Print Clearly)

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Gender: _____ Marital Status: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell: _____

Alternative Phone: _____ **APPOINTMENT REMINDERS**: Email ☐ **OR** Text ☐

Emergency Contact: _____ Relationship: _____ Phone: _____

Work Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Student

Referring Physician: _____ How did you hear about us? _____

Is your injury the result of: ☐ Worker's Comp ☐ Auto-Accident Date of Injury: _____ State: _____

INSURANCE INFORMATION

Primary Insurance: _____ Relationship to Subscriber: _____

Policyholder Name: _____ DOB: _____

Secondary Insurance: _____ Relationship to Subscriber: _____

Policyholder Name: _____ DOB: _____

Worker's Comp (if applicable): Payer Name: _____ Claim #: _____

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, provide treatment and care as prescribed by my physician and/or recommended by my therapist.

I certify that the information I have reported regarding my insurance coverage is correct and authorize the release of necessary information, including medical information, to my insurance carrier to determine benefits.

PATIENT AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize Momentum Physical Therapy, 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. Either my insurance carrier or I may revoke this authorization at any time in writing.

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

The services you have elected to participate in imply 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 plan maximum, you will be responsible for your account balance in full. You are responsible for any amounts not covered by your insurer.

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

Patient Signature: _____ **Date**: _____

(Parent or Guardian if patient is a minor)