

# Momentum Sports Rehab

## Patient Information

**WELCOME:** Please complete the information below in order for us to serve you better.

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_  
Cell Phone # or other contact #: \_\_\_\_\_ Date of injury \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Home# \_\_\_\_\_ Work# \_\_\_\_\_

### RESPONSIBLE PARTY (Please complete if different than patient)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone# \_\_\_\_\_ Social Security# \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ Work# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**If you are a Medicare patient, when were you first seen by your doctor for the injury?**

### INSURANCE COVERAGE

Please provide your insurance card(s) so that we may scan it into the computer.

**Momentum Sports Rehab**

Patient Medical History

**Tell us about you.....**

Name \_\_\_\_\_ Age \_\_\_\_\_ Social Security# \_\_\_\_\_

(Last name, first name) Please Print

Why were you referred for physical therapy? Please describe how and when your injury occurred?

\_\_\_\_\_

In the last year, have you undergone any surgical procedures? Yes \_\_\_\_\_ No \_\_\_\_\_

In the last year, have you been admitted to a hospital? Yes \_\_\_\_\_ No \_\_\_\_\_

What was the condition/surgery? \_\_\_\_\_

Is this condition the reason you were referred for physical therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you received any physical therapy during the past year? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, for what condition? \_\_\_\_\_ Where \_\_\_\_\_

**From 0-10 what would you rate your pain level today** \_\_\_\_\_

Occupation \_\_\_\_\_

Is the majority of your day spent(check one) Sitting \_\_\_\_\_ Standing \_\_\_\_\_ Walking \_\_\_\_\_

At the present time, what are the most difficult tasks for you to perform:

At work? \_\_\_\_\_

At home? \_\_\_\_\_

What is the heaviest object you lift at work? \_\_\_\_\_

What is the weight? \_\_\_\_\_

How many times during the day do you lift this object? \_\_\_\_\_

Have you been unable to work? Yes \_\_\_\_\_ No \_\_\_\_\_ Last day worked \_\_\_\_\_

If you are unable to work at your regular job, do you expect to return to work? \_\_\_\_\_

What is the heaviest object you lift at home? \_\_\_\_\_

What is the weight? \_\_\_\_\_

How many times during the day do you lift this object? \_\_\_\_\_

What type of exercise activities do you currently do? \_\_\_\_\_

Do **you** have a history of:

High Blood Pressure Yes\_\_ No\_\_ Pacemaker Yes\_\_ No\_\_ Exposure/Treatment TB Yes\_\_ No\_\_

Heart Condition Yes\_\_ No\_\_ Seizures Yes\_\_ No\_\_ Cough for > 2 weeks Yes\_\_ No\_\_

Stroke Yes\_\_ No\_\_ Cancer Yes\_\_ No\_\_ Fever for > 2 weeks Yes\_\_ No\_\_

Diabetes Yes\_\_ No\_\_ Falls Yes\_\_ No\_\_ Unexplained weight loss Yes\_\_ No\_\_

Dizziness Yes\_\_ No\_\_ Other Yes\_\_ No\_\_ Night Sweats Yes\_\_ No\_\_

Are you pregnant now or is there a chance you may be pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Have you received any special tests related to your injury/condition? Yes \_\_\_\_\_ No \_\_\_\_\_

(Ex: CAT-Scan, EMG, ECG, MRI) If yes, please specify: \_\_\_\_\_

Are you taking any medications? If so, what type and for what condition? \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed with Patient \_\_\_\_\_ Date \_\_\_\_\_

## Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services **Momentum Sports Rehab** creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the used and disclosures for certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without any prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or healthcare operations be restricted. I also understand that the practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

X \_\_\_\_\_ DATE \_\_\_\_\_  
Patient or Guardian's Signature

X \_\_\_\_\_  
Patient or Guardian's name printed                      Social Security Number for identification purposes only

# Momentum Sports Rehab

## OUR OFFICE INSURANCE POLICY

1. In effort to keep physical therapy cost down while maintaining a high level of professional care, we have established the following financial policies for payment of treatment.
2. Co-payment is due in full for each visit unless prior arrangements have been made with our financial manager. We accept cash, check, Mastercard, Visa, American Express, Discover Card and debit cards. Installment payment plans can be arranged.
3. We file your insurance as a courtesy.
4. We do not assume any responsibility if your insurance company does not pay on your filed claim. You are responsible for charges if your insurance policy is terminated.
5. We will accept payment from your insurance company. Current insurance information must be on file and updated each visit. The patient is required to make the co-payment at the time of treatment. **THE PATIENT IS RESPONSIBLE FOR ANY NON-COVERED OR UNPAID INSURANCE BALANCE AFTER 45 DAYS FROM THE DATE OF TREATMENT.** Any treatment not paid by your insurance for any reason is your responsibility.
6. **If you are unable to keep your appointment, you must notify us within 24 hours.**
7. Returned checks are subject to a \$25.00 service fee.
8. If you are being seen as an out of network patient you will be seen just as if you were in network and charged the same as you are at in network facilities.

I understand the office insurance policy and agree to the terms.

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Signature of responsible party

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Date

# Momentum Sports Rehab

## RELEASE OF INFORMATION

All information provided herein is true and correct. I hereby consent to treatment.

I give permission to **Momentum Sports Rehab** to release information verbal and written, contained in my medical records, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality assurance purposes.

I have read and understand the above release.

X \_\_\_\_\_ DATE \_\_\_\_\_  
(Patient or Guardian Signature)

## ASSIGNMENT OF BENEFITS

I authorize payment directly to **Momentum Sports Rehab** for services.

X \_\_\_\_\_ DATE \_\_\_\_\_

All individuals shall be accorded impartial access to treatment regardless fo race, gender, national origin, disability, health status, religion, age, sexual orientation or sources of payment for care.