Momentum
Physical Therapy 160 Flynn Avenue ● Burlington, Vermont 05401 ● Phone 802 864-6262 ● Fax 802 864-6252

PATIENT REGISTRATION FORM

DATE _____

PATIENT NAME *(FIRST)* _____ *(MI)* _____ *(LAST)* _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___ GENDER M F Other:_____ SS # ___ ___ ___ / ___ ___ / __ __ __ __

PHONE *(HOME)* _____ *(WORK)* _____ *(CELL)* _____

EMAIL ADDRESS: _____

EMPLOYER _____ JOB TITLE _____*FULL TIME or PART TIME*

STUDENT YES NO *(WHERE)* _____ *FULL TIME or PART TIME*

EMERGENCY CONTACT _____ *(PHONE)* _____ *(RELATIONSHIP)* _____

INJURY / ACCIDENT DATE _____

REFERRING DOCTOR:

(FIRST) _____ *(LAST)* _____

(CITY) _____ *(STATE)* _____

PRIMARY CARE PHYSICIAN:

(FIRST) _____ *(LAST)* _____

(CITY) _____ *(STATE)* _____

HOW DID YOU HEAR ABOUT US? IF A FRIEND, PLEASE TELL US WHO SO WE MAY THANK THEM _____

PRIMARY INSURANCE INFORMATION:

TYPE OF INSURANCE ____ WORK COMP ____ MEDICAID ____ MEDICARE ____ GROUP ____AUTO (MVA)

INSURED / POLICY HOLDER NAME *(FIRST)* _____ *(MI)* ____ *(LAST)* _____

RELATIONSHIP ___SELF___SPOUSE ___MOTHER ___FATHER ___OTHER

*(ADDRESS)*_____ *(CITY)* _____ *(STATE)* _____ *(ZIP)* _____

(HOME PHONE) _____ *(WORK)*_____ *(DATE OF BIRTH)* _____

EMPLOYER _____

WORKERS COMP INFORMATION:

INSURANCE COMPANY NAME _____ ADDRESS _____

TELEPHONE # _____ CASE MANAGER NAME _____

CLAIM # _____

Momentum
Physical Therapy 160 Flynn Avenue ● Burlington, Vermont 05401 ● Phone 802 864-6262 ● Fax 802 864-6252

PATIENT INFORMATION FORM

TODAY'S DATE _____

Name_____ Age_____ D.O.B. _____

Preferred Pronoun: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs

Employer_____

Date of Injury/Onset of Pain_____

Referring Physician_____ Next appointment with referring physician _____

Chief Complaint: What is the nature of your pain or problem? _____

_____

_____

Have you seen any other health professional(s) for this or any other condition? YES NO

If yes, who? _____ **Approximately how many times this year?** _____

Injury work related? YES NO Injury motor vehicle related? YES NO If yes, are you currently working with an attorney for this? YES NO

Name and Address of attorney _____

Are you taking any medications? Please list (or we are happy to make a photocopy of your list): _____

_____

Are you allergic to LATEX? YES NO Any other allergies? _____

Do you now have, or have you had, any of the following?

Heart disease/attack	YES NO	High blood pressure	YES NO
Dizziness	YES NO	Joint Pain	YES NO
Cancer	YES NO	Osteoporosis	YES NO
Pregnant (currently)	YES NO	Chronic Headaches	YES NO
Previous surgeries	YES NO	Previous Physical Therapy	YES NO
Diabetes	YES NO	Tooth or jaw pain	YES NO
Seizures	YES NO	Other Health Issues	YES NO

If you answered YES to any of the above, please explain and give approximate dates: _____

_____

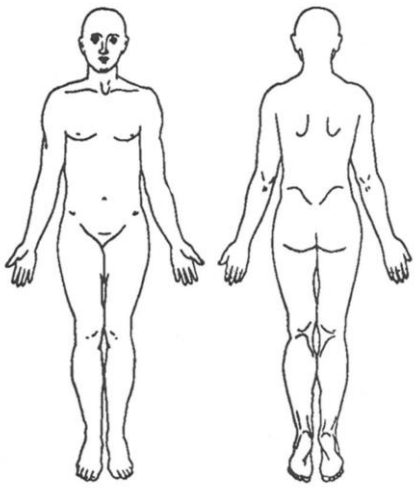
Have you had any of the following? ☐ MRI ☐ X-Ray ☐ CT Scan

If yes, where? _____

Is there anything else you feel we should know to assist in your treatment?

_____

_____



Please indicate on the pictures to the right the locations of your pain.
Please indicate your level of pain at its WORST and BEST on the scale below

0 1 2 3 4 5 6 7 8 9 10

0=NO PAIN 10=EXCRUCIATING PAIN

Momentum
Physical Therapy 160 Flynn Avenue ● Burlington, Vermont 05401 ● Phone 802 864-6262 ● Fax 802 864-6252

Acknowledgment of Receipt of Notice
MOMENTUM PHYSICAL THERAPY, LLC

Maura Guyer, PT, PRC Privacy officer

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship: _____

Name of patient: _____

For office use only:

Signed form received by: _____

Acknowledgment refused:

Efforts to obtain:

_____

_____

Reason for refusal: _____

_____

Momentum
Physical Therapy 160 Flynn Avenue ● Burlington, Vermont 05401 ● Phone 802 864-6262 ● Fax 802 864-6252

MEDICALLY INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of services at Momentum Physical Therapy. It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services.

This consent shall be ongoing for a period not to exceed one year.

I _____ have read this form and fully understand and accept its terms and conditions.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to Momentum Physical Therapy and understand that I am financially responsible for non-covered services. I understand that if Momentum Physical Therapy does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize the physician and/or Momentum Physical Therapy to release any information necessary in order to process any and all claims. All of the information provided is correct and true to the best of my knowledge.

Individuals working with an Athletic Trainer and will be billing under health insurance require (by Vermont State law) a referral from a physician, osteopathic physician, podiatrist, dentist, or chiropractor.

In addition, I understand and agree with Momentum Physical Therapy's "no-show," / cancellation / rescheduling policy: I will be charged a $25.00 fee in the event that I miss an appointment, cancel and / or reschedule in less than a 24-hour period. Personal/Athletic Training clients will be charged for a full session.

_____

Signature of patient or guardian Date

_____

Witness signature