Momentum
physical therapy, p.c.

PATIENT DATA SHEET

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards to our office at your first visit. It is the patient's responsibility to notify our office of any changes to your information listed on this form.

PATIENT INFORMATION

NAME: _____
Last First Middle

ADDRESS: _____
Street City State Zip

PHONE: _____
Home Mobile Work

E-mail: _____ **Would you like to receive our monthly e-newsletter? ____ Y ____ N**

DATE OF BIRTH _____ **SOCIAL SECURITY (Last 4 digits):** _____ **SEX**: Male____ Female ____

Married_____ **Single**_____ **Widowed**_____ **Separated**_____ **EMPLOYER:** _____

REFERRING PHYSICIAN: _____ **PRIMARY PHYSICIAN:** _____

EMERGENCY CONTACT:_____ PHONE: _____
Name/Relationship

***THE ABOVE PERTAINS TO THE PATIENT ONLY.**

If the patient IS A MINOR, then the responsible party completes the next section. If the patient IS NOT a minor, then skip the next section.

RESPONSIBLE PARTY INFORMATION RELATIONSHIP TO PATIENT: _____ Mother _____ Father _____ Self _____ Other

NAME: _____
Last First Middle

ADDRESS: _____
Street City State Zip

PHONE: _____
Home Mobile Work

E-mail: _____

DATE OF BIRTH_____ SOCIAL SECURITY (Last 4 digits): _____ SEX: Male____ Female ____

INSURANCE INFORMATION **ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? _____YES _____NO**

PRIMARY INSURANCE NAME: _____ **INSURED NAME:** _____

PRIMARY INSURANCE ADDRESS: _____
Street City State Zip

POLICY ID:_____**GROUP ID**: _____ **SEE COPY OF CARD:** _____

SECONDARY INSURANCE NAME: _____ **INSURED NAME:** _____

SECONDARY INSURANCE ADDRESS: _____
Street City State Zip

POLICY ID: _____GROUP ID: _____ **SEE COPY OF CARD:** _____

_____ RESPONSIBLE PARTY'S INITIALS

MOMENTUM PHYSICAL THERAPY, PC
PATIENT HISTORY QUESTIONNAIRE

PLEASE FILL OUT THE FORM AS COMPLETE AS POSSIBLE; IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT OR GARDIAN.

NAME: _____ DATE OF BIRTH: _____

OCCUPATION: _____ HOBBIES: _____

PLEASE TELL US THE PRIMARY REASON YOU ARE SEEKING TREATMENT: _____

_____

_____

DATE OF INJURY: _____ PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET

HAS INJURY PREVENTED YOU FROM WORKING? YES NO IF YES, HOW LONG OFF WORK? _____

WORK STATUS: AT THE **PRESENT TIME** I AM ABLE TO:

_____ Work without restriction
_____ Work the same job with restrictions
_____ Work a different job with restrictions
_____ Unable to work due to dysfunction
_____ Don't normally work outside the home
_____ Homemaker
_____ Retired
_____ Other

IS AN ATTORNEY INVOLVED WITH THE CASE? YES NO

IF YES, ATTORNEY NAME: _____ PHONE: _____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

_____ No other treatment
_____ Massage Therapy
_____ Physical/Occupational Therapy
_____ Psychiatrist/Psychologist
_____ Chiropractor
_____ Other

LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:_____

_____

LIST ALL OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:_____

_____

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS WHICH MAY BE PERTINENT TO YOUR TREATMENT:_____

_____

_____

ARE YOU CURRENTLY HAVING OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 3 MONTHS?

_____ Fever
_____ Chills
_____ Pins/Needles
_____ Night Sweats
_____ Shortness of Breath
_____ Skin Rash
_____ Headaches
_____ Numbness
_____ Vision Problems
_____ Hearing Loss
_____ Bowel/Bladder Problems

_____ RESPONSIBLE PARTY'S INITIALS

PLEASE CHECK ALL THE FOLLOWING CONDITIONS THAT APPY TO YOU EITHER PRESENTLY OR IN THE PAST:

_____ High Blood _____ Pressure Epilepsy/Seizures_____ Gout _____ Varicose Veins
_____ Kidney Disease _____ Chest Pain/Heart Attack _____ Hepatitis _____ Dizziness/Fainting
_____ Stroke _____ Asthma _____ Arthritis _____ Depression
_____ Heart Disease _____ Emphysema/Bronchitis _____ Tuberculosis _____ Lung Disease
_____ Thyroid Problems_____ Emotional/Psychological Problems _____ Chemical Dependency (alcohol/drugs)
_____ Cardiovascular Disease

_____ ALLERGIES: _____

_____ OTHER:_____

HAVE YOU RECENTLY EXPERIENCED ANY SIGNIFICANT CHANGES IN?
_____ Mood _____ Energy Level _____ Interest/Pleasure in daily activities
_____ Recent thoughts of death or harming yourself _____ Sudden Loss/Gain of appetite or weight

Do you smoke? _____ YES _____NO. How many packs per day? _____

Do you drink Alcohol? _____ YES _____NO. How many drinks per day? _____

Are there any other substances that you regularly use?_____

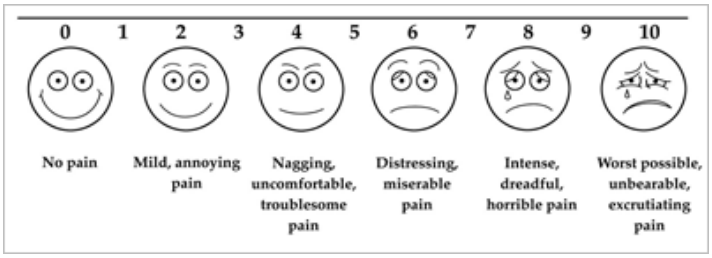
ARE YOU AWARE OF YOUR DIAGNOSIS? _____ YES _____NO.

DO YOU HAVE QUESTIONS REGARDING YOUR DIAGNOSIS OR PROGNOSIS? _____ YES _____NO.

WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? _____

_____

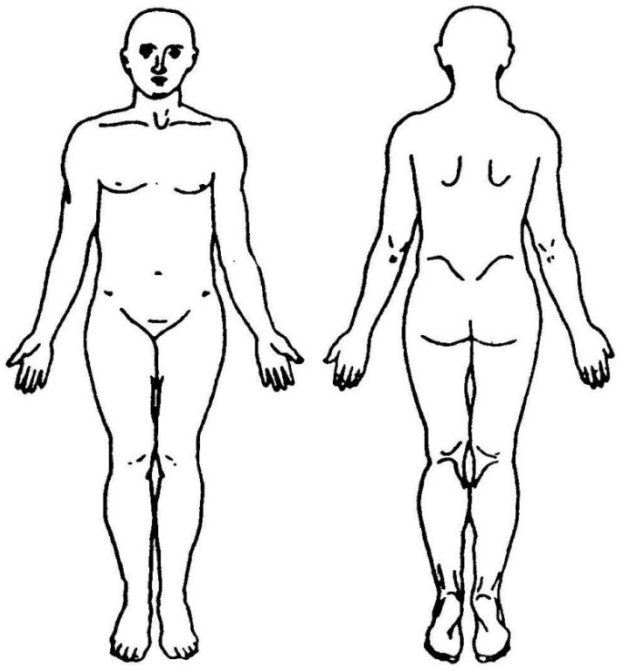
RATE YOUR AVERAGE DISCOMFORT WITH AN "X" ON THE NUMBER SCALE BELOW.



OTHER COMENTS OR CONCERNS YOU MAY HAVE?

PLEASE MAP YOUR AREAS OF DISCOMFORT OR ALTERED SENSATION ON THE BODY MAP.

XXX = PAIN OOO = NUMB/TINGLE *** = WEAKNESS



_____ RESPONSIBLE PARTY'S INITIALS

PATIENT FINANCIAL POLICY

This is an agreement between Momentum Physical Therapy, PC (Creditor) and the Patient (Debtor) named on this form.

In this agreement the words "you", "your" and "yours" mean the patient, the word account means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us" and "our" refer to Momentum Physical Therapy, PC.

By executing this agreement, you are agreeing to pay for all services and supplies that are received.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, if any, any new charges owing to the account, any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

REQUIRED PAYMENTS: Any co-payments or co-insurance required by an insurance company must be paid at the time of service. We shall have the right to cancel your privilege to make charges against your account at any time and require that visits must be paid at the time of service.

CONTRACTED INSURANCE: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-payment, deductible or co-insurance, you must pay that at the time of service. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. Although we may estimate what your insurance company may pay in the patient responsibility portion, it is the insurance company that makes the final determination of payment and eligibility.

NON-CONTRACTED INSURANCE: Insurance is a contract between you and your insurance company. It is the patient's responsibility to verify if our office is a contracted or non-contracted provider. As a non-contracted provider, there is no adjustment write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

PRIMARY INSURANCE: Whenever possible, we will verify your insurance benefits and eligibility prior to your first appointment. It is the patient's responsibility to be aware of your own benefits and eligibility. If your insurance company notifies us that they are waiting to receive the Accident report from you, the balance is automatically patient responsibility and we will begin collection procedures. ***As a courtesy to you, we will bill your primary insurance; however, if our office has not received payment after 120 days from the date first billed to your primary insurance, the balance will become patient responsibility unless other arrangements are made with us.***

SECONDARY INSURANCE: As a courtesy to you, we will bill your secondary insurance after primary insurance has paid. ***If our office has not received payment from your secondary insurance after 120 days from the date first billed to your secondary insurance, the balance will become patient responsibility unless other arrangements are made.***

REFERRALS/PRESCRIPTION/AUTHORIZATION: If your insurance company requires a referral, prescription or preauthorization, you are responsible for obtaining it. Failure to obtain the referral, prescription and/or preauthorization may result in a lower payment or no payment from the insurance company.

WORKER'S COMPENSATION: If your claim is in deferred status, we will ask for private medical insurance to bill if your claim is denied. We require approval/authorization by the workers compensation carrier prior to your initial visit. If your claim is denied and you do not have private medical insurance, you will be responsible for payment in full. If your claim is in litigation, we do require verification of this from your attorney and/or workers compensation carrier.

PERSONAL INJURY/MOTOR VEHICLE ACCIDENTS (MVA): If you are being treated as part of a personal injury lawsuit or claim, we may require verification from your attorney. In addition to this verification, we require you allow us to bill your health insurance. In the absence of insurance other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred in a personal injury case. If you have medical payments (Med Pay) through your motor vehicle insurance, we will bill them as primary insurance and will bill your private health insurance when your Med Pay benefits are used up. We will NOT bill, nor receive any payment from, the "At Fault" or "Third Party" responsible for the accident.

INSURANCE BENEFITS: Patient Responsibility

_____ Deductible

_____ Co-Pay/Approximate Co-insurance

_____ RESPONSIBLE PARTY'S INITIALS

(Continued on page 2)

BENEFIT ASSIGNMENT: You assign all medical benefits to us including health insurance, Medicare, Auto Insurance, Worker's Compensation, or other insurance plans. You also authorize Momentum Physical Therapy, PC to release all information necessary (including photocopies of medical records) to secure payment (See Standards for Privacy of Individually Identifiable Health Information). You agree that if insurance pays directly to you, this monetary amount is actually due us and is patient responsibility.

BILLING INFORMATION: It is your responsibility to provide us with the correct information including insurance, responsible party, date of injury, type of accident, policy and/or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply us with incorrect information, the balance of the account at the last date of service will be entirely patient responsibility. We will not be responsible for rebilling, appealing or other dealings with newly provided insurance companies.

DIVORCE: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child would be the parent responsible for those subsequent charges. If the divorce decree requires the other party to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Methods of Payment: We accept Visa, MasterCard, personal checks and cash. There is a fee of $30 for any checks returned by your bank.

Past Due Accounts: If your account becomes past due, we may need to take necessary steps to collect this debt. This may include contacting the person listed as emergency contact on your patient data sheet, if we have to refer your account to a collection agency; you agree to pay all of the collection costs which are incurred. If we refer your account to a collection agency, we will add a surcharge of 30% to your balance, if we have to refer collection of the balance to a lawyer; you agree to pay all lawyers' fees which we incur plus all court costs.

Missed. Appointment Fee: a $30 fee may be charged for appointments canceled with less than 24 hours notice. The $30 fee will be charged for no-show or missed appointments. This fee must be paid before a new appointment is made. This fee is not billable or payable by insurance. Patients with more than two missed appointments will be discharged from therapy and refer back to their physician. We understand that emergencies do occur and will attempt to make reasonable accommodations for that.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

TYPE OF CLAIM

Is this injury due to an accident?

____ YES ____NO Date of Accident: _____

Was the injury due to a motor vehicle accident (either in the past or current)? ____ YES ____NO

Date of Injury: _____

Did this injury occur in the job? ____ YES ____NO

Do you have an open workers compensation claim? ____ YES ____NO

Date of Injury: _____

This information must be completely filled out on the patient data sheet.

I have been informed of my financial responsibility and agree to the terms and conditions as stated on this form. By signing this form, I consent to and authorize my therapist to examine and treat me today. I understand that my therapist is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.

Patient Name:_____Responsible Party (if not the patient):_____

Signature:_____ Date:_____

Momentum Physical Therapy, PC
1939 Wilmington Drive
Fort Collins, CO 80528

PLEASE SIGN APPLICABLE AREAS

1. IF PATIENT IS UNDER 18: I give permission for the child in my care to be treated by Momentum Physical Therapy, PC.

Responsible Party Signature:_____ Date: _____

2. INSURANCE ASSIGNMENT AND RELEASE: I, the undersigned certify that I (or my dependent) directly assign insurance benefits, if any, otherwise payable to me for services rendered to Momentum Physical Therapy, PC. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____ Date: _____

3. MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Momentum Physical Therapy, PC any services furnished me by the office. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services, I understand that I am responsible for the deductible, co-insurance, and any non-covered service.

Beneficiary Signature:_____ Date: _____

MOMENTUM PHYSICAL THERAPY, P.C.
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY

MOMENTUM PHYSICAL THERAPY P.C.'s LEGAL DUTY

MOMENTUM PHYSICAL THERAPY, P.C. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

MOMENTUM PHYSICAL THERAPY, P.C. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, MOMENTUM PHYSICAL THERAPY, P.C. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. MOMENTUM PHYSICAL THERAPY, P.C. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, MOMENTUM PHYSICAL THERAPY, P.C.'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. MOMENTUM PHYSICAL THERAPY, P.C. will consider all such request on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that MOMENTUM PHYSICAL THERAPY, P.C. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

For further information on MOMENTUM PHYSICAL THERAPY, P.C.'s health information practices or if you have a complaint, please contact the following person:

MOMENTUM PHYSICAL THERAPY, P.C.
Michael J. Ressler M.S., MPT, CSCS
1939 Wilmington Dr. Suite 101 Fort Collins, Colorado 80528
Telephone: 970.377.1422 Fax: 970.377.1839