NEW PATIENT INTAKE FORM

PLEASE FILL OUT THE FOLLOWING FORM AS COMPLETE AS POSSIBLE; IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE OF YOU. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT OR GUARDIAN.

Momentum physical therapy, p.c.

PATIENT INFORMATION:

NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ SOCIAL SECURITY (LAST 4 DIGITS): _____ ◯ MALE ◯ FEMALE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ ◯ MARRIED ◯ SINGLE ◯ WIDOWED ◯ SEPARATED

EMAIL: _____

WOULD YOU LIKE TO RECEIVE PAPERLESS STATEMENTS (AN ADDITIONAL $4 CHARGE WILL BE ADDED TO ALL PAPER STATEMENTS)
◯ YES ◯ NO

WOULD YOU LIKE TO RECEIVE OUR MONTHLY E-NEWSLETTER: ◯ YES ◯ NO

EMERGENCY CONTACT: _____ PHONE: _____
NAME/RELATIONSHIP

REFERRING PHYSICIAN/SURGEON: _____ PRIMARY PHYSICIAN: _____

IF THE PATIENT IS A MINOR THE RESPONSIBLE PARTY MUST COMPLETE THE FOLLOWING SECTION*

RESPONSIBLE PARTY INFORMATION: RELATIONSHIP TO THE PATIENT: ◯ MOTHER ◯ FATHER ◯ GUARDIAN

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ EMAIL: _____

DATE OF BIRTH: _____ SOCIAL SECURITY (LAST 4 DIGITS): _____ ◯ MALE ◯ FEMALE

INSURANCE & BENEFIT INFORMATION: ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? ◯ YES ◯ NO

PRIMARY INSURANCE NAME: _____

SECONDARY INSURANCE NAME: _____

IS YOUR INJURY RELATED TO EITHER OF THE FOLLOWING: ◯ N/A

◯ WORKERS COMP WORKERS COMP CARRIER: _____ CASE #:_____

◯ PERSONAL INJURY/MOTOR VEHICLE ACCIDENT CLAIM #: _____
IS AN ATTORNEY INVOLVED WITH THE CASE: ◯ YES ◯ NO
ATTORNEY NAME: _____ PHONE: _____

HAS YOUR INJURY PREVENTED YOU FROM WORKING: ◯ YES ◯ NO

CURRENT WORK STATUS:

◯CONTINUED WORK WITHOUT RESTRICTIONS ◯ WORK THE SAME JOB WITH RESTRICTIONS
◯WORK A DIFFERENT JOB WITH RESTRICTIONS ◯ UNABLE TO WORK

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PATIENT HISTORY:

OCCUPATION: _____ HOBBIES: _____

EMPLOYER: _____

PRIMARY REASON FOR SEEKING TREATMENT:

_____

_____

_____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION AT ANOTHER FACILITY: ◯ YES ◯ NO
IF SO WHAT KIND OF TREATMENT:
◯ PSYCHIATRIST/PSYCOLOGIST ◯ MASSAGE THERAPY ◯ CHIROPRACTOR ◯ OTHER PYHSICAL THERAPIST

DATE OF INJURY/SURGERY: _____ ◯ SUDDEN ONSET ◯ GRADUAL ONSET ◯ SURGERY
ARE YOU AWARE OF YOUR DIAGNOSIS: ◯ YES ◯ NO
DO YOU HAVE QUESTIONS REGARDING YOUR DIAGNOSIS OR PROGNOSIS: ◯ YES ◯ NO

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

_____

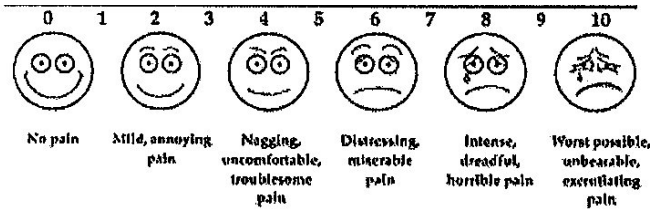
_____

WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY:

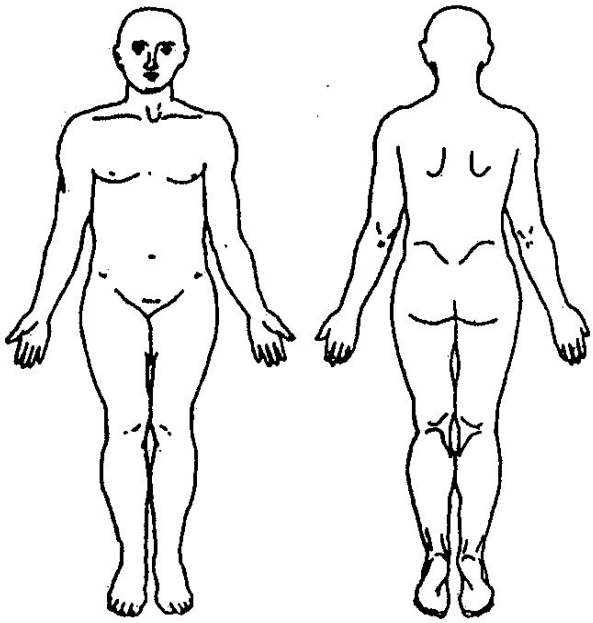
_____

_____

RATE YOUR AVERAGE DISCOMFORT ON THE SCALE BELOW:



PLEASE MAP YOUR AREAS OF DISCOMFORT OR ALTERED SENSATIONS BELOW:
XXX = PAIN OOO= NUMB/TINGLING *** = WEAKNESS



ANY OTHER COMMENTS OR QUESTIONS YOU MAY HAVE:

_____

_____

_____

_____

_____

_____

Momentum
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NEW PATIENT INTAKE FORM

PLEASE FILL OUT THE FOLLOWING FORM AS COMPLETE AS POSSIBLE; IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE OF YOU. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT OR GUARDIAN.

LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

LIST ALL OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

ARE YOU CURRENTLY HAVING OR HAVE YOU 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

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

◯ HIGH BLOOD PRESSURE ◯ GOUT ◯ VARICOSE VEINS ◯ DIABETES
◯ CHEST PAIN/HEART ATTACK ◯ HEPATITIS ◯ DIZZINESS/FAINTING ◯ STROKE
◯ ASTHMA ◯ ARTHRITIS ◯ DEPRESSION ◯ KIDNEY DISEASE
◯ HEART DISEASE ◯ TUBERCULOSIS ◯ LUNG DISEASE ◯ CARDIOVASCULAR DISEASE
◯ THYROID PROBLEMS ◯ CANCER ◯ EMPHYSEMA/BRONCHITIS
◯ EPILEPSY/SEIZURES ◯ CHEMICAL DEPENDENCEY (ALCOHOL/DRUGS)
◯ EMOTIONAL/PSYCHOLOGICAL PROBLEMS

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

PLEASE LIST ALL ALLERGIES:

_____

_____

DO YOU SMOKE: ◯ YES ◯ NO IF YES: HOW MANY PACKS PER DAY: _____

DO YOU DRINK ALCOHOL: ◯ YES ◯ NO IF YES: HOW MANY DRINKS PER DAY: _____

ARE THERE ANY SUBSTANCES YOU USE REGULARLY: _____

_____

_____

MOMENTUM PHYSICAL THERAPY, PC
1939 WILMINGTON DR.
FORT COLLINS, CO 80528

PLEASE SIGN ALL APPLICABLE AREAS

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:_____

CONSENT TO TREAT: I HAVE BEEN INFORMED OF MY FINANCIAL RESPONSIBILITY AND AGREE TO THE TERMS AS STATED. BY SIGNING BELOW 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 PROCEDURE AND TREATMENT, AND THAT I HAVE THE RIGHT TO REFUSE THE RECOMMENDED TREATMENT.

RESPONSIBLE PARTY SIGNATURE:_____ DATE:_____

CONSENT TO TREAT IF THE PATIENT IS UNDER 18: I GIVE PERMISSION OF THE MINOR IN MY CARE TO BE TREATED BY MOMENTUM PHYSICAL THERAPY, PC:

PARENT OR GUARDIAN SIGNATURE:_____ DATE:_____

MEDICARE AUTHORIZATION: I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO MY OR ON MY BEHALF TO MOMENTUM PHYSICAL THERAPY, PC FOR ANY SERVICES FURNISHED TO ME BY THE OFFICE. I AUTHORIZE ANY HOLDER OF MEDICAL 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 SERVICES.

RESPONSIBLE PARTY SIGNATURE:_____ DATE:_____

MOMENTUM PHYSICAL THERAPY, PC
1939 WILMINGTON DR.
FORT COLLINS, CO 80528

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" REFER TO THE PATIENT, THE WORD ACCOUNT REFERS TO THE ACCOUNT ESTABLISHED IN THE PATIENTS 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 ANY NEW CHARGES OWING TO THE ACCOUNT. UNLESS OTHER AGREEMENTS HAVE BEEN APPROVED BY US IN WRITING, THE BALANCE ON YOUR STATEMENT IS DUE WITHIN 30 DAYS OF WHEN THE STATEMENT IS ISSUED, AND IS CONSIDERED PAST DUE IF NO PAYMENT IS RECEIVED IN THOSE 30 DAYS. YOU MAY OPT INTO OUR PAPERLESS BILLING TO RECEIVE YOUR STATEMENTS MONTHLY VIA EMAIL. IF YOU OPT OUT OF PAPERLESS BILLING AN ADDITIONAL $4 CHARGE WILL BE ADDED TO ALL STATEMENTS THAT ARE PRINTED AND MAILED.

REQUIRED PAYMENTS: ANY COPAYS OR COINSURANCE REQUIRED BY AN INSURANCE COMPANY MUST BE PAID AT THE TIME OF SERVICE. WE RESERVE THE RIGHT TO CANCEL YOUR PRIVILEGE TO MAKE CHARGES AGAINST YOUR ACCOUNT AT ANY TIME AND REQUIRE THAT THE 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-PAY, DEDUCTABLE OR CO-INSURANCE, YOU MUST PAY THIS 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 MY PAY IN THE PATIENT RESPONSIBILITY PORTION, IT IS THE INSURANCE COMPANY THAT ULTIMATELY MAKES THE FINAL DETERMINATION OF PAYMENT AND ELIGIBILITY.

NON-CONTRACTED INSURANCE: INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. IT IS THE PATIENTS RESPONSIBILITY TO VERIFY IF OUR OFFICE IS A CONTRACTED OR A 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, THEN THE BALANCE IS AUTOMATICALLY PATIENT RESPONSIBILITY AND WE WILL BEGIN THE COLLECTION PROCESS.

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 THE PRIMARY INSURANCE HAS PAID.***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.***

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 OR PREAUTHORIZATION MAY RESULT IN A LOWER PAYMENT OR NO PAYMENT FROM THE INSURANCE COMPANY.

METHODS OF PAYMENT: WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS, PERSONAL CHECKS AND CASH. THERE IS A $30 FEE FOR ANY CHECKS RETURNED BY YOUR BANK.

BENEFIT ASSIGNMENT: IF YOU ASSIGN ALL MEDICAL BENEFITS TO US INCLUDING HEALTH INSURANCE, MEDICARE, AUTO INSURANCE AND WORKERS COMPENSATION, OR ANY OTHER INSURANCE PLANS, YOU ALSO AUTHORIZE MOMENTUM PHYSICAL THERAPY, PC TO RELEASE ALL INFORMATION NECESSARY (INCLUDING PHOTO COPIES OF MEDICAL RECORDS) TO SECURE PAYMENT. YOU MUST AGREE THAT IF THE INSURANCE PAYS DIRECTLY TO YOU, THIS MONETARY AMOUNT IS ACTUALLY DUE TO US AND IS THE PATIENTS RESPONSIBILITY TO PAY MOMENTUM THE REQUIRED AMOUNT.

_____**RESPONSIBLE PARTY'S INITIALS**

MOMENTUM PHYSICAL THERAPY, PC
1939 WILMINGTON DR.
FORT COLLINS, CO 80528

PATIENT FINANCIAL POLICY (CONTINUED)

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 NUMBER, ETC. SHOULD ANY OF THIS INFORMATION CHANGE IT IS YOUR RESPONSIBILITY TO UPDATE IT WITH US IN 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 THE NEWLY PROVIDED INSURANCE COMPANY.

DIVORCE: IN THE CASE OF A DIVORCE OR SEPARATION, THE PARTY RESPONSIBLE FOR THE ACCOUNT PRIOR TO THE DIVORCE OR SEPARATION WILL REMAIN RESPONSIBLE FOR THE ACCOUNT. AFTER A DIVORCE OR SEPARATION, THE PARENT AUTHORIZING TREATMENT FOR THE MINOR WOULD BE THE RESPONSIBLE PARTY FOR THOSE SUBSEQUENT CHARGES. IF THE DIVORCE DECREE REQUIRES THE OTHER PARTY TO PAY ALL OR PART OF THE TREATMENT COST, IT IS THE AUTHORIZED PARTIES RESPONSIBILITY TO COLLECT IT.

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 YOUR EMERGENCY CONTACT. 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 YOUR BALANCE TO A LAWYER, YOU AGREE TO PAY ALL LAWYERS' FEES WHICH WE INCUR PLUS ALL COSTS.

MISSED APPOINTMENT FEES: A $30 FEE MAY BE CHARGED TO YO ACCOUNT FOR APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE. A $30 FEE MAY BE CHARGED TO YOUR ACCOUNT FOR A NO-SHOW OR MISSED APPOINTMENT. THIS FEE MUST BE PAID BEFORE A NEW APPOINTMENT CAN BE MADE. THIS FEE IS NOT BILLABLE OR PAYABLE BY INSURANCE. PATIENTS WITH MORE THAN TWO MISSED APPOINTMENTS OR LATE CANCELATIONS IN A ROW WILL BE DISCHARGED FROM THE PRACTICE AND REFERRED 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.

WORKERS COMPENSATION: IF YOUR CLAIM IS IN DERRED 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 THE PAYMENT IN FULL. IF YOUR CLAIM IS IN LITIGATION, WE DO REQUIRE VERIFICATION OF THIS FROM YOUR ATTORNEY AND WORKERS COMPENSATION CARRIER.

PERSONAL INJURY/MOTOR VEHICLE ACCIDENT (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 TO ALLOW US TO BILL YOUR HEALTH INSURANCE. IN THE ABSENCE OF INSURANCE OTHER FINANCIAL ARRANGEMENTS MAY BE DISCUSSED. PAYMENT OF THE BILL REMAINS THE PATIENTS RESPONSIBILITY. WE CANNOT BILL YOUR ATTORNEY FOR CHARGES INCURRED IN A PERSONAL INJURY CASE. IF YOU HAVE MEDICAL PAYMENTS 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.

FINANCIAL POLICY AGREEMENT AND RELEASE: I HAVE BEEN INFORMED OF MY FINANCIAL RESPONSIBILITY AND AGREE TO THE TERMS AND CONDITIONS AS STATED ON THIS FORM.

PATIENT NAME: _____

RESPONSIBLE PARTY (IF NOT THE PATIENT): _____

RESPONSIBLE PARTY SIGNATURE:_____ DATE:_____

MOMENTUM PHYSICAL THERAPY, PC
1939 WILMINGTON DR.
FORT COLLINS, CO 80528

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 THE INFORMATION. PLEASE REVIEW CAREFULLY.

MOMENTUM PHYSICAL THERAPY, PC'S LEGAL DUTY
MOMENTUM PHYSICAL THERAPY, PC 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 OR HEALTH INFORMATION
MOMENTUM PHYSICAL THERAPY, PC 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, PC* MAY USE YOUR PERSONAL HEALTH INFORMATION TO CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS, INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH RELATED BENEFITS THAT COULD BE OF INTEREST TO YOU. *MOMENTUM PHYSICAL THERAPY, PC* 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, PC'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.

PATIENTS 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, EXCEPT WHEN SPECIFICALLY AUTHORIZED BY YOU, WHEN REQUIRED BY LAW OR IN EMERGENCY CIRCUMSTANCES. *MOMENTUM PHYSICAL THERAPY, PC* WILL CONSIDER ALL SUCH REQUESTS 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, PC* 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, PC* HEALTH INFORMATION PRACTICES OR IF YOU HAVE A COMPLAINT, PLEASE CONTACT THE FOLLOWING PERSON:

MOMENTUM PHYSICAL THERAPY, PC
MICHAEL J. RESSLER M.S., MPT, CSCS
1939 WILMINGTON DR. SUITE 101 FORT COLLINS, CO 80528
P: 970.377.1422 F: 370.377.1839