WELCOME TO MOMENTUM THERAPEUTICS

Greenville Office

G ________ ________Today's Date

Please Print

PATIENT INFORMATION

Name ______________________________ Employer's Name______________________________

Address ______________________________ Employer's Address______________________________

City, State, & Zip ______________________________ City, State & Zip ______________________________

Phone ( ) ______________________________ Employer's Phone ( )______________________________

SS# ________________ Birthdate______________ Occupation ______________________________

☐ Male ☐ Female Retired? ☐ Yes ☐ No

☐ Married ☐ Single ☐ Widowed ☐ Divorced Email Address ________________@________________

PERSON RESPONSIBLE FOR THE BILL (Self if over age 18, legal guardian if under age 18)

Name ______________________ Birthdate ______________ SS#______________________

Relationship______________ Phone ( )______________ Work Phone( )______________

Address ______________________ City______________ State__________ Zip __________

Employer______________________________ Occupation______________________________

Employer's Address ______________________ City, State & Zip ______________________

EMERGENCY CONTACT: ______________________ Relationship ______________ Phone(____)______________

INJURY INFORMATION Please Check One

Work Injury ☐⟶	Injury Date	Claim #
Auto Injury ☐⟶	Injury Date State where accident occurred ______	Policy #
No Injury ☐	Home Injury ☐	

PLEASE HAVE YOUR INSURANCE CARDS READY

A BILLING DEPARTMENT REPRESENTATIVE WILL DISCUSS COVERAGE WITH YOU

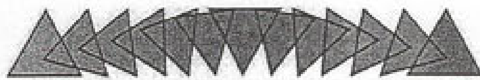
OFFICE USE ONLY

HIPAA Acknowledgment Signed **Yes ___** **No ___**

Exceptions **Yes ___** **No ___**

Explain: ____

Rev. 11/11 db



MOMENTUM THERAPEUTICS
MEDICAL INFORMATION FORM

Check all the following that apply to you:

____Angina/Chest Pain/Heart Attack/Bypass/Stents ____________________
____Asthma/Emphysema/Shortness of Breath/COPD ____________________
____Pacemaker _____ Stroke _____ Frequent Headaches/Migraines
____High/Low Blood Pressure________ Medication Controlled ____________________
____Diabetes (Foot Protection Required) ________Medication______________ Insulin______________
____Cancer (Radiation/Chemotherapy) ____________________
____Prostate (radioactive seeds) ______Persistent Night Pain
____Seizures/Epilepsy
____Dizziness/Vertigo/Balance Problems/Motion Sickness ____________________
____Perforated Ear Drum/Inner Ear Infection
____Vaginal Bleeding ____________________
____Gastric Bypass/Lap-Band
____Rectal Bleeding/Hemorrhoids ____________________
____Rheumatic Fever/Fever____________________
____Tuberculosis
____On Oxygen/Coumadin _____History of Blood Clot . . . Where/When?____________________
____Osteopenia/Osteoporosis ____________________
____Peripheral Neuropathy ____________________
____Fibromyalgia____________________
____Bowel/Bladder (Incontinence)/Kidney Dialysis ____________________
____Diarrhea __(2 days or less – no pool for 48 hours after resolution) __(2 days + no pool for 2 weeks) __(after resolution)
____Infections: Bladder/Yeast/MRSA/Urinary Tract Infection ____________________
____Burns/Blisters (location) ____________________
____Open: Wounds/Cuts/Abrasions (location) ____________________
____Skin Conditions: Athlete's Foot / Poison Ivy / Shingles / Scabies / Lice / Warts / Rash / Psoriasis / Eczema
____Hernia: Hiatal/Groin/Abdominal
____Pregnant
____Smoker ____Packs/Daily ____Number of Years
____Other: ____________________
____Allergies: ____________________
Medications: ____________________
____
____
Hospitalizations/Surgeries: ____________________
____
____
What do you feel started the problem that brought you here? ____________________
____

YES	NO	
___	___	Unexplained cough for more than 3 weeks ____________________
___	___	Unexplained weight loss ____________________
___	___	Fever/chills ____________________
___	___	Night sweats ____________________
___	___	Loss of appetite ____________________

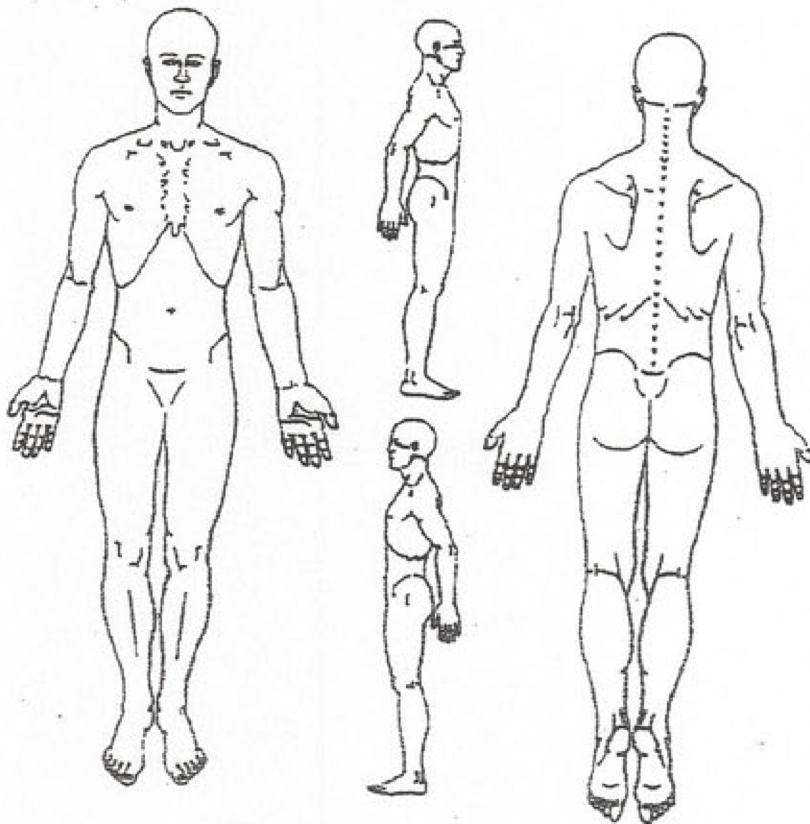
Date______________
Patient Name (PRINT) ____________________ Signature ____________________

Therapist Signature ____________________

6/11 db

Pain Diagram and Rating

Patient's Name ______________________
PLEASE PRINT



Please use the symbols to describe the type of **pain or sensation you are currently experiencing on the diagram**

- Ache = A
- Burning = B
- Tingling = T
- Dull = D
- Numbness = N
- Sharp = S

☐ Other, describe it: ______________

Please mark the **severity of pain**

- Current pain: 0 1 2 3 4 5 6 7 8 9 10
- Worst pain in last 2 weeks: 0 1 2 3 4 5 6 7 8 9 10
- Least pain in last 2 weeks: 0 1 2 3 4 5 6 7 8 9 10

Patient Signature ______________________ Date ______________

MOMENTUM THERAPEUTICS
41 6TH AVENUE
GREENVILLE, PA 16125

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Momentum Therapeutics (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 41 6th Avenue, Greenville, PA 16125, Attention: Practice Compliance Director.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): ____________________

   ____

5. I specifically authorize the Practice to share my protected health information with the individuals listed below. Until I revoke such authorization to release my protected health information to the individuals who appear on this list or otherwise provide written instructions to the Practice setting forth limitations on the information to be provided to such individuals, the Practice is specifically authorized to release any and all of my protected health information to the individuals listed below. I understand that I can specify limitations on the information that is permitted to be disclosed by listing such limitations below the individuals name herein:

   Authorized Person: ____________________
   Limitations on Release of Information: ____________________

   Authorized Person: ____________________
   Limitations on Release of Information: ____________________

   Authorized Person: ____________________
   Limitations on Release of Information: ____________________

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

____________________ ____________________
Signature of Patient or Representative   Date

____
Patient's Name

____
Date of Birth

____
Social Security Number

____________________ ____________________
Name of Personal Representative (if applicable)   Relationship to Patient

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To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

________ Accepted   ________ Denied   ________ Not Applicable

________ Other (explain) ____________________

____________________ ____________________
Signature of Authorized Practice Representative   Date

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