

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 <input type="checkbox"/>	→ Injury Date _____	Claim # _____
Auto Injury <input type="checkbox"/>	→ Injury Date _____ State where accident occurred _____	Policy # _____
No Injury <input type="checkbox"/>	Home Injury <input type="checkbox"/>	

PLEASE HAVE YOUR INSURANCE CARDS READY
A BILLING DEPARTMENT REPRESENTATIVE WILL DISCUSS COVERAGE WITH YOU

OFFICE USE ONLY

HIPAA Acknowledgment Signed
Exceptions

Yes _____
Yes _____

No _____
No _____

Explain: _____

MEDICAL INFORMATION FORM

Patient Name: _____

PAST MEDICAL HISTORY

Please indicate if you have ever been diagnosed with any of the following conditions:

YES	NO	
_____	_____	Angina/Chest Pain/Heart Attack _____
_____	_____	Asthma/emphysema/shortness of breath _____
_____	_____	Pacemaker _____
_____	_____	Bowel/Bladder problems _____
_____	_____	Rectal/vaginal bleeding _____
_____	_____	Cancer _____
_____	_____	Diabetes _____
_____	_____	Dizziness, passing out or balance problems _____
_____	_____	High/low blood pressure _____
_____	_____	Seizures _____
_____	_____	Tuberculosis (TB) _____
_____	_____	Osteoporosis _____
_____	_____	Rheumatic fever _____
_____	_____	Are you pregnant? _____
_____	_____	Allergies, please list _____
_____	_____	Other, please list _____

Please list any medications that you take: _____

Please list any hospitalizations & surgeries (and when): _____

What do you feel started the problem that brought you here? _____

GENERAL HEALTH

Are you experiencing any of the following:		
YES	NO	
_____	_____	Unexplained cough for more than 3 weeks _____
_____	_____	Unexplained weight loss _____
_____	_____	Fever/chills _____
_____	_____	Night sweats _____
_____	_____	Loss of appetite _____

I certify that the information provided regarding my medical history is correct & complete to the best of my knowledge

Patient Signature X _____ Date _____

Therapist Signature _____

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 disclose 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

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