Momentum Physical Therapy

Patient Express Registration

Patient Information (Required)

Name: _____ Date of Birth: _____ Gender ____M ____F

Street Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Mobile Phone: ( ) _____

Email: _____

Primary Contact Method: Home Phone _____ Mobile Phone _____ Email _____

__ I wish to receive emails regarding my treatment such as appointment updates, home exercise programs, and other communication.

__ I wish to receive emails regarding special offers/new discounts, new programs, and newsletters with health tips and advice from Momentum Physical Therapy.

Emergency Contact Information (Required)

Emergency Contact Name: _____ Relationship to Patient: _____

Phone: ( ) _____ Email:_____

How Did You Find Out About Us? (Optional)

_____

Consent for Treatment and Authorization To Charge Credit Card (Required)

I consent to be evaluated and treated and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the release of information acquired in the course of my treatment, including but not limited to medical records, electronic and oral communications, to my insurance company representatives, employer, primary care physicians, referring MD and/or other third party payer.

Credit Card Type: _____ Last Four Digits of Credit Card: _____

I hereby authorize charges to the indicated credit card above for services rendered and/or if I fail to give at least 24 hour notice prior to cancellation or rescheduling of my appointments.

Patient Signature: _____ Date: _____

Cancellation Policy (Required)

A specific time is reserved for you when you schedule an appointment. If you cannot keep your appointment, please call our office at least 24 hours in advance so we can reschedule your appointment and offer the reserved time to another patient.

There will be a $70 charge for any no show or cancellation with less than 24 hour notification. You agree to be personally responsible for this charge that is NOT covered by your insurance.

Patient Signature: _____ Date: _____

Momentum Physical Therapy

Patient Intake Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you.

Patient Name: _____ Age: _____ Occupation: _____

Have you seen any of the following during the past six (6) months:

___ Medical Doctor (MD) ___ Psychiatrist/Psychologist ___ Osteopath
___ Physical Therapist ___ Dentist ___ Chiropractor

If you marked a check above, please describe:_____
_____
_____

Have you EVER been diagnosed as having any of the following conditions?

Yes No - Heart Problems
Yes No - High Blood Pressure
Yes No - Heart Arrhythmia
Yes No - Stroke
Yes No - Circulation Problems
Yes No - Asthma
Yes No - Thyroid problems
Yes No - Diabetes
Yes No - Multiple Sclerosis
Yes No - Rheumatoid Arthritis
Yes No - Other Arthritic Conditions
Yes No - Kidney Disease
Yes No - Emphysema/Bronchitis
Yes No - Cancer: _____
Yes No - Incontinence
Yes No - Anemia
Yes No - Epilepsy
Yes No - Tuberculosis
Yes No - Depression
Yes No - Hepatitis
Yes No - Other

Have you recently noticed?

Yes No - Weight Loss/Gain
Yes No - Nausea/Vomiting
Yes No - Fatigue
Yes No - Weakness
Yes No - Fever/Chills/Sweats
Yes No - Numbness or Tingling

FOR WOMEN:
Are you currently or think you might be pregnant? Yes No

Please list any hospitalizations:

Date	Reason for Surgery/Hospitalization

Please list any significant injuries (fractures, dislocations, etc):

Date	Injury

Please list all OVER-THE-COUNTER medications you are currently taking:

_____
_____
_____
_____

Please list all PRESCRIPTION medications you are currently taking:

_____
_____
_____
_____

To the best of my knowledge, this information is complete and accurate.

Patient Signature: _____ Date: _____

Momentum Physical Therapy
Statement of Privacy Notice
Effective February 5, 2007

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

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional
Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (310) 473-8287.

If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (310) 473-8287. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Momentum Physical Therapy with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Printed Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Momentum Physical Therapy
Physician-Patient Arbitration Agreement
Effective February 5, 2007

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuitor resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or associations, corporations, partnerships, employees, agents, clinics, and/or providers (herein after collectively rendered to as “Physician”) to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and mother's expected child or children. Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing by U.S. Mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patients, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant of the Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rate share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effec**t: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Severability Provision**: In the event any provision(s) of this Agreement is declared void an/or unenforceable,such provision(s) shall be deemed severed therefrom the remainder of the Agreement enforces in accordance with California law.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

Patient’s Printed Name: _____ Date: _____

Patient or Representative Signature: _____ Date: _____

Momentum Physical Therapy

Financial Policies and Assignment of Benefits

Financial Policies

You've made an excellent decision by choosing Momentum Physical Therapy. We take great pride in providing you with a superior physical therapy experience. We are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

1. If you request, we will help you process your insurance claim form for your reimbursement. In order to do this, we will need your complete insurance information. Please bring your insurance card(s) with you to your first appointment. We will keep a copy of this information on file. If your insurance changed, please notify us immediately.
2. If you are a member of Prefered Provider Organization (PPO) or Medicare, we will follow your plan's guidelines for billing and collections. You will be required to pay any deductibles and copayments which you owe, or for any services which you agree to, but which are not covered by your insurance. Co-payments, co-insurances, and deductibles are due at the time of your visit.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. If you do not have insurance coverage, you are expected to pay for our services, in full, at the time of each visit.

Assignment of Benefits

I hereby instruct and direct my insurance company to pay by check made out & mailed to:
Momentum Physical Therapy - 11500 West Olympic Blvd, Suite 470, Los Angeles, CA 90064

If my current policy prohibits direct payment to the doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional and medical expense benefits allowable, and otherwise payable to me under my current insurance policy payment towards the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of this assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to an insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize Momentum Physical Therapy to deposit checks made in my name.
- I authorize Momentum Physical Therapy to initiate a complaint to the Insurance Commissionerfor any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

I have read and agree to all the policies mentioned above.

Patient Signature: _____ Date: _____