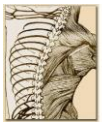


MANUAL THERAPY ASSOCIATES INC.

Patient demographics Today's date: _____

Name: _____ Date of birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ home: _____ Email: _____

Name of insurance: _____ (for information only) MTA will not bill insurance.

Chief complaint: _____

Who can we thank for referring you? Friend Family Other? _____

Emergency contact: _____ phone: _____

Is your injury related to a motor vehicle accident? Yes /No

If you answered yes, please complete questions 1-5, otherwise skip to signature line.

1. Date of injury: _____
2. do you have an attorney? Name/phone number: _____
   _____
3. Auto insurance company: _____
4. Adjustor name: _____ phone number: _____
5. Claim number: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorized Manual Therapy Associates, INC to release any information acquired in the course of my treatment necessary to process insurance claims. I hereby consent to treatment as deemed necessary by the treating physical therapist(s) and referring physicians(s).

CANCEL / NO-SHOW: Please note that you will incur a **$60.00** fee for a cancellation less than 24 hours in advance. If you do not call prior to your appointment a no-show fee equal to amount of your visit will be incurred. **($80 or $150)**

I certify that I have read and understand the above hold harmless clause and release of information clause. The information I have provided on this form is true and correct to the best of my knowledge. A copy of this form is valid as the original.

X _____ date: _____

Patient/legal guardian signature

12001 W. 63rd place, Suite 202, Arvada CO 80004 Ph: 303-668-2898 /Fax: 303-456-0220

Manual Therapy Associates, Inc

Advanced Hands on Care for A Faster Recovery

Patient Name_____ Date _____

Allergies: List any medication(s) you are allergic to:_____

Current medications / vitamins / supplements:_____

Do you smoke? Yes / No how much:_____ Do you drink alcohol? Yes / No how much_____

Do you consume caffeinated beverages? Yes / no how much:_____

Are you engaged in any regular exercise? Please describe:_____

Are you under a lot of pressure or stress? Yes / no please describe:_____
Do you have a pacemaker, transplanted organ, joint replacement, or metal implants?_____

Have you had any illness in the last 3 weeks (colds, flu, bladder or kidney infection)? _____

Females Only: *Are you pregnant or planning a pregnancy?*_____
Severe troublesome menstrual cramps? _____
Have you ever been diagnosed with?

- O *Pelvic inflammatory disease*
- O *Endometriosis*
- O *Other gynecological or obstetrical difficulties?*_____

Males Only: *Do you have history of prostate disease / cancer or infection:* _____

Have you ever had any of the following? (check all that apply)

- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Blood disorder (transferable)
- ☐ Blood in the stool
- ☐ Bone disease
- ☐ Breast lumps/pain
- ☐ Cancer
- ☐ Chest Pain / pressure / tightening
- ☐ Chronic cough
- ☐ Diabetes
- ☐ Difficulty hearing
- ☐ Dizzy spells
- ☐ Difficulty walking
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Digestive problems
- ☐ Fibromyalgia
- ☐ Frequent urination
- ☐ Groin pain/swelling
- ☐ Headaches
- ☐ Heart attack
- ☐ Heart palpitations
- ☐ Hernia
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypertension
- ☐ Incontinence
- ☐ Increases pain at night
- ☐ Kidney disease
- ☐ Kidney infection
- ☐ Latex sensitivity
- ☐ Liver disease
- ☐ Memory loss
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pain or difficulty urinating
- ☐ Polio
- ☐ Poor balance
- ☐ Ringing in the ears
- ☐ Scoliosis (curvature of spine)
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Skin disorder
- ☐ Stroke
- ☐ Swelling of neck or glands
- ☐ TB/Ling disorder
- ☐ Thyroid disorder
- ☐ Ulcers / stomach problems
- ☐ Unexplained weight gain/loss
- ☐ Urinary infection

Please explain any positive answer from previous page here: _____

_____

_____

Family History

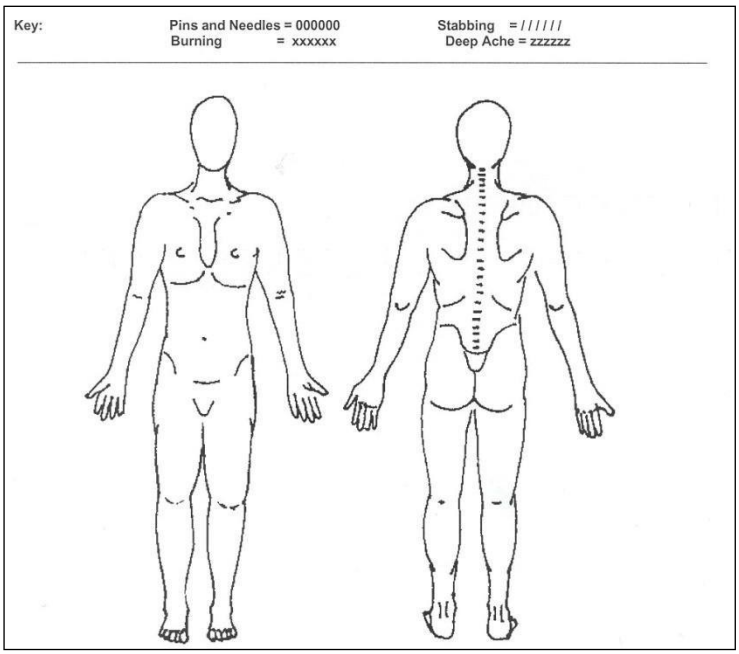
- ☐ Alcoholism (chemical dependency)
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Thyroid disease / dysfunction

Have you recently noted?

- ☐ Fatigue
- ☐ Fever / chills / sweats
- ☐ Nausea / vomiting
- ☐ Numbness / tingling
- ☐ Weakness
- ☐ Weight gain / loss

Manual Therapy Associates, Inc

Advanced Hands on Care for A Faster Recovery



Please rate your current level of pain on the following scale (mark line):

_____

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (mark line):

_____

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please list 3 activities that you are having difficulty doing or are unable to do. Please rate these activities on following scale.

0 1 2 3 4 5 6 7 8 9 10
Unable To perform Activity — Able to do the same as before injury

Activity	Baseline Score	6-week Score	1-year Score
Example: Climb Stairs	8		
1.			
2.			
3.			

Patient Signature X_____ Date X_____

Therapist Signature X_____ Date X_____

Arvada

Phone: 303-668-2898 Fax: 303-456-0220

Manual Therapy Associates, Inc

Advanced Hands on Care for A Faster Recovery

Notice of Privacy Practices for Protected Health Information
Effective May 27, 2008

Why
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes a national privacy standard to protect the privacy of your health information. This standard requires that Manual Therapy Associates, Inc. notify you of our Privacy Practices.

Who
All Manual Therapy Associates, Inc. employees, staff, contractors and affiliated associates are required to follow the notice.

What
In the process of receiving medical services for Manual Therapy Associates, Inc. you will be providing us with personal information such as your name, address, phone number, medical history and insurance coverage information. "Circle of Care" individuals and entities such as your primary care physician, health plan(s), clinics, friends and family may also provide information surrounding your care. This information is considered Protected Health Information (PHI) and is required to be solely used and disclosed for the purpose described below.

How
Manual Therapy Associates, Inc. may use and disclose individually identifiable and personal medical information about you for the purposes listed below without additional authorization. If you do provide us with additional authorizations, in writing, you may revoke your authorization, in writing, any tine. This will not affect any transactions performed during the authorized time period.

Treat, Payment and Healthcare Operations: Manual Therapy Associates, Inc. may use or disclose your health information for the purposes of providing treatment and payment services. In addition, we may also use and disclose your health information for the purpose of healthcare operations. Healthcare operations include but are not limited to reviewing the performance of practitioners and staff, quality assurance, training, certification and accreditation programs and credentialing.
Required disclosures: Manual Therapy Associates, Inc. must disclose your health information to the Secretary of Health and Human Services (HHS) and Office of Civil Rights (OCR) regarding our compliance with the HIPAA regulations. Furthermore, we are required to disclose your health information to federal, state or local law enforcement, military authorities, nation security agencies, public health agencies, or other institutions with lawful custody of your PHI.
Business Associates: Manual Therapy Associates, Inc. does work with outside individuals and organizations to assist in our day-to day operations. We may disclose health information to these business associates on a need-to-know basis. They are required to protect the confidentiality of your PHI to the same extent as Manual Therapy Associates, Inc.
Person's Involved in Care: We may use and disclose health information with persons responsible with your care or may aide in your care about your location, payment, general health, or death. Under emergency situations we will perform these uses and disclosures without your authorization.

Abuse and Neglect: We may disclose health information for cases of abuse, neglect, or domestic violence when required by law or authorized by the patient.

YOUR PATIENT RIGHTS

Access upon request and with limited exceptions Manual Therapy Associates, Inc. is required, to disclose and provide copies of your own health information. This request must be made in writing. In order to cover expensed and staff time, a reasonable charge of $.25 per page plus postage, when necessary, will be made for requested copies of your health information. You may request that your information be provided in a format other than photocopy. We will provide that format, when practical, and extend any additional fees.

Accounting: You are entitled to receive a accounting of all the disclosures of your health information to individuals or organization not involved in your treatment, payment or healthcare operations. The accounting of these disclosures will start on April 14, 2003. And remain accounted for at lest 6 years.

Restriction: You have he right to ask for restrictions on the ways we use and disclose your health information for treatment, payment, and health care operations purposes. Though not required to do so, we will comply with any agreement(s), except in emergency situations, to restrict the use and disclosure of your health information.

Amendment: You may request, in writing that we amend your health information. The request must state the reasons for the request along with a detailed description of the amendment. Under certain circumstances we reserve the right to deny your amendment request.

Alternate Communications: You may request that we communicate with you concerning your health information by alternative means and alternative locations. The request must be in writing and include the specific means, locations, and provide an acceptable clarification on how payment will be addressed.

Paper Format: You have the right to request this form in paper format.

Marketing: We will not use or disclose your health information for marketing purposes, without you're written authorization.

12001 West 63RD Place #5
Arvada, CO 80004
Phone: 303-456-2671 Fax: 303-456-0220

Manual Therapy Associates, Inc

Advanced Hands on Care for A Faster Recovery

Notice of Privacy Practices for Protected Health Information
Effective May 27, 2008

Receipt of Notice of Privacy Practices

Patient Name:_____

[redacted]_____

I hereby acknowledge that I have read and understand Manual Therapy Associates, Inc. Notice of Privacy Practices. If you so choose, you have the right to refuse to sign this acknowledgement.

Date: _____

Patient / Legal Representative Signature: _____

Legal Representative Name *(if applicable)*:_____

Contact Person with whom we may discuss your care and give results.

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
Name	**Relationship**	**Phone Number**

May we leave confidential information on voicemail or answering machines listed below?

Home Phone_____ **Yes**_____ **No**_____

Work Voicemail_____ **Yes**_____ **No**_____

Cell Voicemail_____ **Yes**_____ **No**_____

FOR INTERNAL USE ONLY

We were unable to obtain written acknowledgement of our Notice of Privacy Practices. It could not be obtained due to:

- ❑ Patient / legal representative refusal to sign.
- ❑ The following emergency situation:

_____
_____

- ❑ The following communication difficulties:

_____
_____

COMPLAINTS

You may also contact the Secretary of the Department of Health and Human Services for any complaints concerning our privacy practices at:

200 Independence Avenue
Southwest, Room 509F, HHH Building
Washington, DC 20201
Or by email at: orcmail@hhs.gov.

You cannot be penalized or retaliated against by Manual Therapy Associates, Inc. for filing a complaint. Our Privacy Officer is Jennifer Rohling you may contact her at:
12001 W. 63rd Pl. Suite 5 Arvada, CO 80004 Phone (303) 495-5111 Fax (303) 456-0220 This Notice of Privacy Practices is effective as of 5/27/2008