HAWAII PHYSICAL THERAPY, INC. -- PATIENT REGISTRATION FORM

Please fill out this form to register as a patient of Hawaii Physical Therapy, Inc. All fields with an asterisk (*) are REQUIRED. We cannot register you as a Hawaii Physical Therapy, Inc. patient without this information.

PATIENT INFORMATION

*Name: LAST , FIRST M.I.		Account Number:	*SSN:
*Gender: Male ☐ Female ☐	*Date of Birth:	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐	
*Address:		*City:	*State: HI / *Zip Code:
*Home Phone:	Alternate Phone:	Driver License No.:	Email Address:
*Employer/School:		Employ Status: FT ☐ PT ☐ Not Employed ☐ Retired ☐ Active Duty ☐ Self ☐	
Address:		City:	State: / Zip Code:
Work Phone:	Occupation:	Student Status: FT ☐ PT ☐	
*Is this injury related to a Work or Auto accident? Yes ☐ No ☐		Date of Injury:	

GUARANTOR INFORMATION (person that is responsible for the bill)

*Name: LAST FIRST M.I.		*Date of Birth: / /	*SSN: - -
*Address:		*City:	*State: / *Zip Code:
*Home Phone: ( ) -	*Relationship to Patient:	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐	

INSURANCE COVERAGE & SUBSCRIBER INFORMATION (person that has the insurance policy)

*Primary Insurance Name:		*Subscriber's Name: LAST , FIRST M.I.	
*Gender: Male ☐ Female ☐	*Date of Birth:	*SSN:	* Relationship to Subscriber:
*Policy No.:		*Group No.:	*Plan No.:
Secondary Insurance Name:		*Subscriber's Name: LAST , FIRST M.I.	
*Gender: Male ☐ Female ☐	*Date of Birth:	*SSN:	* Relationship to Subscriber:
*Policy No.:		*Group No.:	*Plan No.:
Tertiary Insurance Name:		*Subscriber's Name: LAST , FIRST M.I.	
*Gender: Male ☐ Female ☐	*Date of Birth:	*SSN:	* Relationship to Subscriber:
*Policy No.:		*Group No.:	*Plan No.:

*Emergency Contact:	*Relationship to Patient:	*Phone No.: ( ) -
If patient is a child, who may authorize treatment for this child?	Relationship to Patient:	Phone No.: ( ) -
Nearest friend or relative not residing with you:	Relationship to Patient:	Phone No.: ( ) -

Do you have a telephone answering machine or voicemail in your home? Yes ☐ No ☐
If so, may we leave messages from this office on that machine? Yes ☐ No ☐
May we contact you at work and/or leave messages there? Yes ☐ No ☐

Who is your Primary Care Physician (PCP)?

Do you authorize release of your medical information to anyone besides your insurance carrier(s)? Yes ☐ No ☐
If so, whom?

HAWAII PHYSICAL THERAPY, INC

Attention: All Patients

As a service to our patients, our staff will assist you with the filing of your insurance claims. Each and every insurance plan varies in the amounts and type of medical coverage offered. It is between you and your insurance company to understand your benefits. We will gladly check on your benefits upon your request, however it is to your advantage to understand your plan and be aware of any limitations.

1. If your Primary insurance Company does not cover our services in full, you are responsible for the remaining amounts(s) due.
2. Your insurance plan may have a deductible and/or co-pay that you will be responsible for. As a courtesy to you, we will contact your insurance company to find out your deductible and/or co-pay.
3. We will file with your secondary insurance as long as you provide us with all pertinent information. If you would like our assistance, please notify us immediately so that we can obtain any pre-authorizations that may be necessary (i.e.: Champus, Queen's Health Care Plan, UHA, KHH, etc.)

ATTN: PLS CALL WITHIN 24 HOURS FOR CANCELLATION OR THERE WILL BE A $25.00 CHARGE FOR "NO SHOW."

Attention: Medicare Patients

Effective January 1, 2000 – Medicare will pay 80% of eligible fees after your deductible has been met. Medicare has a $162.00 annual deductible (this may have been met with another doctor seen prior to us). You are responsible for your $162.00 deductible and 20% of the eligible fee.

HMSA 65C+ and Akamai Advantage pays 100% of the eligible fee after patient's co-payment.

Attention: Other Private Insurance Patients (i.e. HMSA, HMO)

It is vital for you to inform the receptionist of any prior physical therapy visits you may have had in the past or are currently attending. This information is necessary so we can follow up on pre-authorizations needed for you to continue therapy. If information is not given, you will be responsible for any payments denied by your insurance company.

You, the patient is responsible for your annual deductible and amounts not covered by your insurance. Most plans cover 80-90% of the eligible charges after your deductible has been met. Although you may have met your deductible while seeing another provider, some plans have a separate deductible for physical therapy (major medical benefits).

As an added benefit to our patients we will gladly assist you in obtaining coverage information, although it is your responsibility to know what your plan covers.

I have read and understand the above statements regarding my insurance plans (if applicable). I authorize HAWAII PHYSICAL THERAPY, INC. or its representative, Billing Services, LLC, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care. I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Champus, private insurance, and any other health plan to HAWAII PHYSICAL THERAPY INC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. In the event of default, I (We) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize HAWAII PHYSICAL THERAPY INC. to release all information necessary to secure payment and treatment.

_____ _____

Patient, Parent or Guardian's Signature: Date

Patient Name**:**

HAWAII PHYSICAL THERAPY, INC.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Hawaii Physical Therapy, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Hawaii Physical Therapy, Inc.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Hawaii Physical Therapy, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Hawaii Physical Therapy, Inc. Privacy Officer at 725 Kapiolani Blvd., Suite 202, Honolulu, HI 96813. With my consent, Hawaii Physical Therapy, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including x-ray or MRI results among others.

With my consent, Hawaii Physical Therapy, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

I have the right to request that Hawaii Physical Therapy, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hawaii Physical Therapy, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hawaii Physical Therapy, Inc. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name: Date

_____

Print Name of Patient or Legal Guardian

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY THE PRACTICE

By signing this authorization, I authorize Hawaii Physical Therapy, Inc. to use the following individually identifiable health information:

Name and mailing address

E-mail address

The information will be used for the following purpose:

E-mail newsletter and other information pertaining to HPT.

In other words, we are asking for your permission to e-mail our newsletter to you.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire:

☐ One year from the date signed

☐ on _____{Expiration Date or Defined Event}

I do not have to sign this authorization in order to receive treatment from Hawaii Physical Therapy, Inc. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Hawaii Physical Therapy, Inc.'s Privacy Officer at 725 Kapiolani Blvd., Suite 202, Honolulu, HI 96813.

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name: Date:

_____

Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

HAWAII PHYSICAL THERAPY, INC.

Medical History Form

Name: *Referring Physician:*

Family Physician: *Date of 1st Doctor visit for this injury/illness:*

_____ _____

Last day worked due to this injury: *Date returned to work after this injury:*

_____ _____

Is an Attorney involved in this case? ☐ *Yes* ☐ *No* *Since what Date:*

_____

Have you had Surgery for this injury? ☐ *Yes* ☐ *No* *Date/Type of surgery:*

_____

Are you or do you think you might be pregnant? ☐ *Yes* ☐ *No* *Do you smoke?* ☐ *Yes* ☐ *No*

Are you Currently taking ANY prescription or Non-prescription medication? ☐ Yes ☐ No

If yes, please list medications: _____

Have you had any of the following Services for this injury/illness? (Please mark all that apply)

☐ Physical Therapy ☐ Orthopedist ☐ Chiropractic
☐ Emergency Room Care ☐ X-rays ☐ CT Scan
☐ MRI ☐ Neurologist ☐ Other: _____

Do you now have or have you EVER had ANY of the following? (Please mark all that apply)

☐ Heart problems or surgery ☐ Asthma or other breathing problems ☐ Gout
☐ Osteoprosis ☐ Emotional/Psychological problems ☐ Infectious disease
☐ Diabetes ☐ Dizziness or Fainting ☐ Sleeping problems
☐ Cancer/Tumor ☐ Thyroid/Goiter problem ☐ Weight or energy loss
☐ High Blood Pressure ☐ Migraines ☐ Any type of implants
☐ Stroke / TIA ☐ Vision or hearing problems ☐ Neck injury/surgery
☐ Seizures / Epilepsy ☐ Anemia ☐ Back injury/surgery
☐ Hernia ☐ Arthritis ☐ Shoulder injury/surgery
☐ Numbness or tingling ☐ Weakness ☐ Hip/knee injury/surgery
☐ Allergies ☐ Vericose veins ☐ Elbow/wrist/hand injury/surgery
☐ Joint replacement ☐ Shortness of breath or chest pain ☐ Leg/Ankle/Foot injury/surgery
☐ Bowel or bladder problems ☐ Pacemaker/Nitroglycerin patch

Please add any other information that you think would be helpful: _____

_____

Has your physician made you aware of the Diagnosis you are being treated for? ☐ Yes ☐ No

What are your expectations/goals for Physical Therapy? _____

_____

Patient/Guardian Signature: _____ Date: _____

This form has been reviewed by: _____ Date: _____

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