Ewa Beach Physical Therapy Patient Registration

Last Name	First Name	Date of Birth	☐ Male ☐ Female ☐ Single ☐ Married
Street Address	City	State	Zip code

Home Phone ( )	Cellular Phone ( )	Work Phone ( )	Email Address
Occupation	Employer Name	Employer Address	
Emergency Contact Person	Emergency Contact Phone # ( )	Relationship to you	Primary or Referring Physician Name
Work Status: ☐ Currently Employed ☐ Retired ☐ Student (__PT or __FT) ☐ Disabled (__ Total or __Temporary)			Next M.D. Appointment Date

I have insurance and would like to … ☐ Have you deal directly with them.

My coinsurance/copay is $ __________ My deductible is $ __________

Primary Insurance Carrier	Subscriber # / Membership # / Policy #	Insured Name	Insured Date of Birth
Relationship to the insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________			
Secondary Insurance Carrier	Subscriber # / Membership # / Policy #	Insured Name	Insured Date of Birth
Relationship to the insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________			

For Worker's Comp. and Automobile Accidents: Date of Injury: ______________ Claim # ____

Insurance Carrier: ________________________ Adjuster's Name: __________________________ Phone # _________________________

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

This payment will not exceed my indebtedness to **Ewa Beach Physical Therapy**, and I have agreed to pay, in a current manner, any balance of said professional service chargers over and above this insurance payment.

(Check each box and sign at the bottom)

☐ 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 any 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 **Ewa Beach Physical Therapy** to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

____ Date_________________

Signature (Patient or parent/guardian if minor)

Physical Therapy Pre-Exam Questionnaire

Age? ______ Working now? Yes ____ No _____

What caused your pain/or problem? ____

Approximately when did it start? ___________ Is it getting better, worse, or staying the same? ___________

Quality of pain? **(circle all that apply)**

ACHE BURNING DULL NUMBNESS PINCHING SHARP SHOOTING

STABBING THROBBING TINGLING

Have your ever had this pain/problem before? Yes ____ No ____

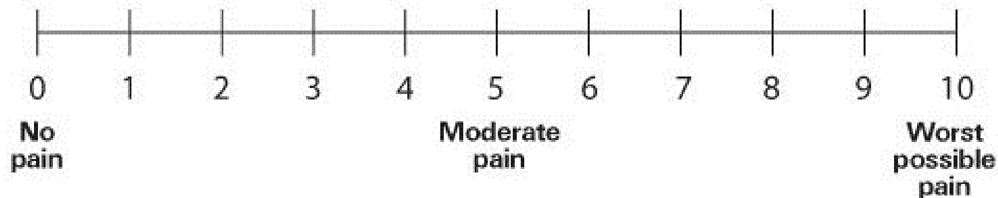
Is your pain constant (never goes away)? Yes ____ No ____

Which of your everyday activities are affected? ____

____

Are you following a current exercise program? Yes ____ No ____

On the scale blow, circle your **LEAST & WORST** pain level in the past couple of days:



Please **CHECK ALL THAT APPLY**

__ ALLERGIES
__ CANCER
__ CHRONIC HEADACHES
__ DIABETES
__ DIZZINESS
__ HEART DISEASE
__ HERNIA
__ HIGH BLOOD PRESSURE
__ KIDNEY PROBLEMS
__ METAL IMPLANTS
__ NERVOUS SYSTEM DISORDER
__ PACEMAKER
__ PRESENTLY PREGNANT
__ PREVIOUS P.T. SERVICES
__ RESPIRATORY DISEASES
__ SEIZURES
__ PREVIOUS SURGERIES
__ TUBERCULOSIS
__ OTHER CONDITIONS THAT MAY AFFECT YOUR P.T.

PLEASE EXPLAIN CHECKED ANSWERS FROM ABOVE AND **GIVE APPROPRIATE DATES**:

____

____

LIST MEDICATION(S) YOU ARE CURRENTLY TAKING:

____

____

PATIENT'S SIGNATURE: ____DATE: _________

GUARDIAN'S SIGNATURE (If a minor): ____DATE: _________

Important Company Policies

We strive to provide you the best personalized care available. To make this possible, we adhere to a set of very important guidelines. Please read them carefully and **indicate your agreement by initialing all boxes**.

☐

Consent to Treat

This consent provides us with your permission to perform reasonable and necessary examinations, testing and treatment. By initialing, you are indicating that (1) your consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

☐

Insurance Deductible

If your insurance has a deductible amount that has not been met, you will be charged for that amount along with your copay/coinsurance, if any.

☐

Late Policy "10-minutes"

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable.

☐

24-Hour Advance Notice Fee

If you wish to change or cancel an appointment, we require a minimum **24-hour advance notice**. Anything less will result in a **$30 fee** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you for the actual cost for that appointment but rather a mere **$30 fee**. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐

No-shows

If you fail to show for an appointment without notice, all future appointments will be removed, and a **$30 fee** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐

Cell phones must be shut OFF or silent

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however please be courteous, and set to silent mode or turned off and do not use during your session. Thank you.

☐

Children requiring supervision are NOT allowed to attend sessions with you

Our facility does not offer child care services, therefore you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly, then you may bring them. If any disturbances are caused to other patients or staff members, you may be asked to terminate your session early and attend to your child.

☐

Important Notice from the Federal Government:

"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments… even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlines in your insurance plan even if you doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's – Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General Department of Health and Human Services. Contact by phone: 202-619-1343, by fax: 202-260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs. Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington D.C. 20201, Joel Schaer. Office of Counsel to the Inspector General, 202-619-0089."

Ewa Beach Physical Therapy

Statement of Privacy Notice

Effective June 1, 2003

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 (808) 689-9994. 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 (808) 689-9994. 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 Ewa Beach Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____
Patient's Signature Date

____
Authorized Facility Signature Date