HOLOMUA PHYSICAL THERAPY
MOVE FORWARD

Confidential Patient Information

Name _____ DOB __ - __ - __ Age ___

Address _____ Apt ___ Phone ___ - ___ - ____

City _____ State ___ Zip ___ Gender ☐ Male ☐ Female

Permanent Address _____ Phone ___ - ___ - ____

City _____ State ___ Zip ___ E-Mail _____

[redacted] ___ - ___ - ____ [redacted] _____ State ___

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

If a minor, parent / guardian name _____

[redacted] ___ - ___ - ____ DOB __ - __ - __

Employer _____ Phone ___ - ___ - ____

Address _____ Ext or Dept _____

City _____ State ___ Zip ___ Hours _____

Occupation _____ Supervisor _____

Spouse _____ DOB __ - __ - __ Age ___

[redacted] ___ - ___ - ____ Phone ___ - ___ - ____

Work ___ - ___ - ____

Employer _____

Address _____

City _____ State ___ Zip ___

Emergency Contact _____ Relationship _____

Address _____ Phone ___ - ___ - ____

City _____ State ___ Zip ___

Referring Physician _____ Next Visit _____

Primary Care Physician _____ Next Visit _____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ Date _____

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Confidential Medical Information

Date of Onset / Injury / Accident _____ ☐ Estimated

Please state current problem(s): _____

_____

Are you currently being treated by:

Another Therapist	____Yes	____No	Or within the last 12 months	____Yes	____No
Chiropractor / Osteopath	____Yes	____No	Or within the last 12 months	____Yes	____No
Home Health Agency	____Yes	____No	Or within the last 12 months	____Yes	____No

Major surgeries since birth: _____

Allergies: _____

List current medications: _____

Check if you currently have or previously had any of the following:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Heart Problems

specify: _____

_____

_____

- ☐ High Blood Pressure
- ☐ Gout
- ☐ Seizures
- ☐ Stroke
- ☐ Ulcers
- ☐ Other Illnesses

specify: _____

_____

_____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ Date _____

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Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Holomua Physical Therapy to furnish medical care and treatment to _____ which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature _____ Date _____
Patient / Guardian

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, ie.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to Holomua Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Holomua Physical Therapy to release all medical information and records necessary to secure payment for services rendered.

Signature _____ Date _____
Patient / Guardian

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by Holomua Physical Therapy , you must promptly remit such payment directly to Holomua Physical Therapy.

If you are a WorkersÕCompensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your WorkersÕCompensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature _____ Date _____
Patient / Guardian

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Patient Privacy Policy & Procedure Statement

Dear Patient:

Holomua Physical Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 808-531-1122.

Holomua Physical Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

Signature _____ Date _____

Patient / Guardian