



**HOLOMUA**  
PHYSICAL THERAPY  
MOVE FORWARD

### Confidential Patient Information

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Gender Identity:** \_\_\_\_\_ **Another identity:** \_\_\_\_\_

**Pronouns:** \_\_\_\_\_ **Another pronoun:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_ *Ok to email?*

If minor, parent/ guardian name: \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

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**Primary Insurance Company:** \_\_\_\_\_

**If not Self, Subscriber's Name:** \_\_\_\_\_ **Subscriber's DOB:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

**If not Self, Subscriber's Name:** \_\_\_\_\_ **Subscriber's DOB:** \_\_\_\_\_

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**Emergency Contact:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient/Guardian



**Confidential Medical Information**

Date of Onset/ Injury / Accident: \_\_\_\_\_ Estimated

Please state current problem(s): \_\_\_\_\_

Are you currently being treated by:

Medical Specialist:

Specify: \_\_\_\_\_

Another Therapist:

Or within the last 12 months

Chiropractor/ Osteopath:

Or within the last 12 months

Major surgeries since birth: \_\_\_\_\_

List current medications: \_\_\_\_\_

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

Allergies

High Blood Pressure

Arthritis

Gout

Asthma

Seizures

Cancer

Stroke

Circulation Problems

Ulcers

Diabetes

Other Illnesses \_\_\_\_\_

Heart Problems

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 assignments of benefits.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian



**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 Workers' Compensation patient, the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation 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



## **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 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 reserved 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