PT HAWAII
94-801 FARRINGTON HWY SIUTE #W2
WAIPAHU, HAWAII 96797
Phone: (808)680-9123 Fax: (808)680-9889

Appointment Policy and Expectations

To Our Valued Patient,

Thank you for choosing PT Hawaii as your physical therapy provider. We hope you enjoy your time with us and have a positive experience as we help you recover from your injury. In order for us to provide you with the best possible care, we ask that you read the following policies regarding scheduling and appointments.

1. Please schedule as many appointments as possible in order to get the times that are best for you.

2. Please try to avoid missing your appointments. Appointment times are often a premium with other motivated patients wanting to get in at the same day and time. If need be, please call the clinic to reschedule or cancel your visit **AT LEAST 24 HOURS IN ADVANCE in order to avoid the $25 cancellation fee.**

3. If a patient has **3 NO-SHOWS** or **CANCELLATIONS in a row**, or if a patient has inconsistent attendance during any given treatment plan, his / her doctor and corresponding insurance adjustor will be notified and further action may be taken concerning availability of physical therapy and / or massage therapy.

4. Being late by more than 10 minutes may require you to reschedule or wait for the next available opening. There are no guarantees of same day reschedules as cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

5. Estimated copays are due upon arrival.

   "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 outlined in your insurance plan even if your doctor allows it. Both parties 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 laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A (a) (5) of the Health Insurance Portability and Accountability Act of 1996 [section 231 (h) of HIPPA]. Exceptional cases do not apply. For questions please contact: 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

6. Children requiring supervision are NOT allowed to attend sessions with you. If any disturbance is caused to other patients or staff members you may be asked to terminate the session early and attend to your child.

7. If you have a severe cold or are sick, we unfortunately will not be able to treat you at this time due to the high risk of infecting other patients and staff members whom you may get in contact with. Please recover quickly and we can resume your appointment session when you feel better.

MAHALO TO BOTH YOU AND YOUR PHYSICIAN FOR CHOOSING PT HAWAII.

Patient's Name (PRINT) _____ Patient's Signature _____ Date_____

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Last Name:	First Name:	Middle Initial:
Address:	City / State:	Zip Code:
Email Address:	Home Phone #:	Cell Phone #:
Date of Birth:	Sex: (circle one): Male Female	Social Security Number:
Referring Physician:	Primary Care Physician:	
Emergency Contact:	Relationship to Patient:	Contact Phone #:

EMPLOYMENT INFORMATION (Required for all Worker's Compensation Injuries)

Employer's Name:	Your Job Title:	Supervisor's Name and Contact Info:
Work Address:	City / State:	Zip Code:

ACCIDENT AND INJURY INFORMATION

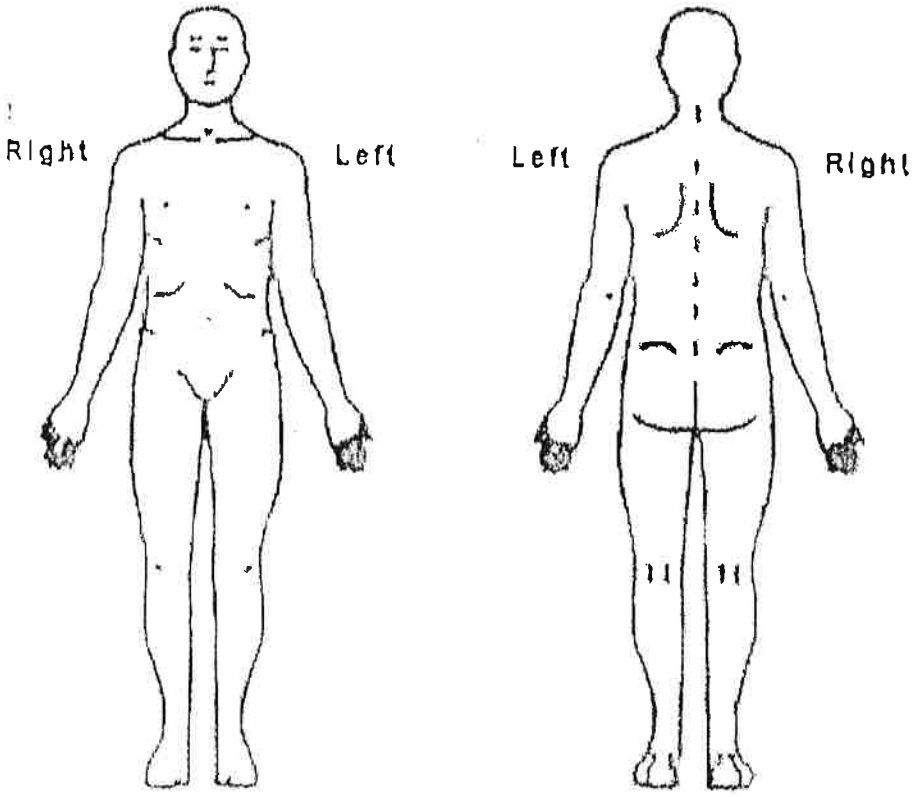
Were you involved in an accident? Yes No	If yes, circle which type: At Work Motor Vehicle	Date of Occurrence:

INSURANCE INFORMATION

WORKERS COMPENSATION: Name of Employer's Worker's Compensation Insurance:	Insurance Address: Claim Number:	Name of Insurance Adjuster: Phone Number:
MOTOR VEHICLE: Name of Motor Vehicle Insurance:	Insurance Address: Claim Number:	Name of Insurance Adjuster: Phone Number:
PRIMARY PRIVATE INSURANCE:	Policy Holder's Name: Date of Birth: Relationship to Policy Holder:	Policy #: Group #:
SECONDARY PRIVATE INSURANCE:	Policy Holder's Name: Date of Birth: Relationship to Policy Holder:	Policy #: Group#:
Attorney's Name:	Attorney's Address:	Attorney Phone #:

WHOM DO WE THANK FOR THIS REFERRAL: _____

Please circle the body parts currently in pain



Please describe your pain:

_____

_____

_____

Approximate start date: _____ My pain / problem is: __getting worse __better __staying the same

My pain is WORSE:

__In the morning __during the day __at night __with activity __during rest __Other _____

My pain is BETTER:

__Sitting __Resting __Lying __Walking __Taking Medication __Other_____

Please check which activities cause you the most pain or limitations:

__Bending __Driving __Exercising __Reaching Overhead __Running __Sitting
__Sleeping __Standing __Walking __Working __Other_____

On a scale of 0 to 10, (0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain: currently_____ at it's best _____ and at it's worse_____

PAST MEDICAL HISTORY

MEDICAL CONDITIONS: __Cancer __High Blood Pressure __Diabetic __High Cholesterol __Thyroid

IMAGING FOR CURRENT CONDITION: ___XRAY ___MRI ___EMG ___ OTHER _____

PAST SURGICAL HISTORY – Please list Date or approximate Age when occurred

PREVIOUS PHYSICAL THERAPY __YES __NO If YES, When & Where _____

GOALS FOR PHYSICAL THERAPY _____

ALLERGIES – Please list all Allergies including Drug Allergies / Food Allergies

MEDICATION LIST – Please list ALL medicine/ drugs patient is currently taking, or present a list of your medication

Medicine / Drug Name	Dose or Amount	Frequency (daily, weekly)

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Statement of Privacy Notice

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 healthcare operations.
- We may disclose your health information as necessary to comply with State Worker's Compensation Laws.
- We may disclose your health information to notify or assist in notifying a family member, another person responsible for your care about your medical conditions or in the event of an emergency or at your death.
- As required by law, we may disclose your health insurance 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 of 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 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 or particular person or to the general public.
- We may disclose your health information for military, national security prisoner and governmental 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 appointments 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, postcard, 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 or 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 the 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 your denial reasons and information about you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by us.
- You have the right to a paper copy of this Notice of Privacy Practice 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, or have complaints about your Privacy rights, or how we handled your health information, please contact us by calling this office (808)680-9123. 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 the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.
- **I have especially understood that HIPPA laws limit PT Hawaii, INC's ability to discuss your private information with your family members, or other persons close to you. If you would like to grant us permission to speak with a person other than yourself regarding your protected health information (including billing information, appointment reminders, scheduling, etc.) please list their names and information in the spaces below.**

THEIR NAME_____ **THEIR NAME**_____

RELATIONSHIP TO YOU_____ **RELATIONSHIP TO YOU**_____

Please **Check** the following, we can communicate with you in regards to above mentioned by:

___ TEXT / PHONE ___ EMAIL ___ ANSWERING MACHINE / ANSWERING SERVICE

Patient's Name (PRINT) _____ Patient's Signature _____ Date_____

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Agreement of Release and Waiver and Liability Consent for Treatment and Services

I, _____ (print name), understand that in order to be allowed to receive care and information on health and fitness provided by PT Hawaii, INC and to use their facilities, I agree and will initial the following:

1. I authorized my physician or such physical therapists or massage therapists as he/she may employ, along with any physical therapy assistants or technicians that may be assigned which they consider appropriate under the circumstances and to continue such treatment from time to time as my physician and/or the treating physical therapists or massage therapists and/or their assistants may deem advisable. The effect and nature of this treatment, its intimate nature, possible alternative methods of treatment, and the risks of treatment, if any, have been explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained. I further understand that PT Hawaii, INC. is a facility primarily owned and operated by Dr. Scott McCaffrey who is also a director, officer and shareholder of WorkStar Occupational Health Systems, INC. (WorkStar). I understand that I am free to choose a different physical therapy and massage therapy provider other than PT Hawaii. _____(initial)
2. Voluntary Participation: I understand and confirm that my use of PT Hawaii's services and facilities is voluntary. _____(initial)
3. Identifications of Risks: I understand that each therapist/trainer will take every precaution to ensure that each client is protected from any potentially hazardous situations. I recognize and assume full responsibility that PT Hawaii, INC's services and equipment may require physical exertion which may be strenuous and cause physical injury; and I am fully aware of the risks and hazards involved, including, but no limited to, equipment that may malfunction or break when prior warning was given, any slip, fall, or dropping of equipment, injury due to patient negligence in following instruction or supervision, aggravation to any pre-existing conditions, bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability. _____(initial)
4. Assumption of Risk: I confirm that an examination/medical clearance by my physician has been obtained prior to involvement in any PT Hawaii's services. I am physically and psychologically ready to use PT Hawaii's facility and assume all risks, known and unknown, foreseeable and unforeseeable, connected with my use of PT Hawaii's facility and services. I accept personal responsibility for any liability, injury, loss or damage in any way affiliated with PT Hawaii, INC. _____(initial)
5. Waiver and Release: I voluntarily and expressly waive any claim I may have against PT Hawaii, INC and its employees for injury or damages that I may sustain as a result of participating in any services. I, on behalf of myself, my personal representatives & heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, & indemnify PT Hawaii, INC & their representatives & employees from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of service or otherwise which may arise out of my use of any equipment or participation in these activities. I understand that I am releasing, discharging, & waiving any claims or actions that I may have presently or in the future for negligent acts or other conduct by the representatives or employees of PT Hawaii, INC. _____(initial)
6. Financial Responsibility and Medical Awareness: I understand I will be participating in voluntary services and I am obligated to ensure payment in full of my fees. I am aware of paying any deductibles and co-payments / co-insurances as determined by my contract of my insurance carrier. I am responsible for any amount not covered by my insurer. If my insurance denies any part of my bill from PT Hawaii, INC., I will be responsible to pay my balance in full. I authorize my insurer to pay any benefits directly to PT Hawaii, INC., the full and entire amount of bill incurred by me, or, if applicable, any amount due after payment has been made by my insurance carrier. _____(initial)
7. Medical Treatment Comfort: Because of the nature of services provided, you may be asked to disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times by the staff. **ALWAYS** communicate with your therapists. Should you feel uncomfortable or embarrassed, you may refuse the procedure and an alternate option will be provided if available. _____(initial)
8. Release of Information: I authorize PT Hawaii, INC. to release any requested medical information or records to any person, organization, or agency which may be liable for payment of any portion of PT Hawaii, INC fees and charges. I authorize PT Hawaii, INC to furnish the attorney that I have retained to represent me for the personal injuries I previously sustained, for which PT Hawaii, INC is now treating me, with any medical information or records pertaining to me. This includes by way of example and not exclusive to a full report of examination, plan of care treatments, and the progress reports. _____(initial)
9. Consent for Patients Who Are MINORS: I am the legal guardian of the patient and authorize her/him and give my consent for the patient to attend PT Hawaii, INC's appointments independently.

I authorize PT Hawaii, INC's physical therapists, massage therapists, and he/she may employ, along with its support personnel (including physical therapy assistants and technicians), to perform the appropriate respective services for the care, injuries or ailments that I am here for. I certify that I have read the above agreement of release and waiver and liability and consent for treatment and services, that any questions that I had about its content have been answered to my full satisfaction, and that I freely give my informed consent to performance of PT Hawaii, INC's services and consent to release my information as above stated.

Patient Name (print)_____ Patient Signature_____ Date _____

Parent / Guardian / Guarantor's Name (print) _____ Signature_____ Date_____