ACTION PHYSICAL THERAPY

Thank you for your interest in Action Physical Therapy. Please print out this PDF file and fill out the forms prior to coming to your first appointment. If you are having trouble filing these forms out or need assistance, please arrive at least 15 minutes prior to your appointment time to complete the needed paperwork.

Mahalo.

office phone:: 808.246.0144 physical address:: 4381 Kukui Grove Street, Suite #3, Lihue, Hawaii 96766
web site:: http://www.ActionPhysicalTherapyKauai.com email:: info@actionPTKauai.com fax:: 808.246.0144

ACTION PHYSICAL THERAPY

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION

NAME (FIRST) (MI) (LAST)			SSN XXX-XX-_____	DOB	SEX M F
ADDRESS			MARITAL STATUS M S D OTHER		
CITY	STATE	ZIP CODE	SCHOOL/EMPLOYER:		
HOME PHONE	WORK PHONE	CELL PHONE	E-MAIL		

ACCOUNT INFORMATION

****HAVE YOU HAD PHYSICAL THERAPY THIS YEAR?**

YES _____ NO _____

HOW MANY VISITS _____

WHEN? MONTH/YEAR _____

DATE OF ONSET/INJURY:

****HAVE YOU HAD PHYSICAL THERAPY FOR THIS BEFORE?**

YES _____ NO _____

EXPLAIN: _____

DATE OF REFERRAL: _____

DATE OF SURGERY:

COMMENTS:

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME	NAME

PRIMARY INSURANCE POLICY		SECONDARY INSURANCE POLICY	
GROUP NUMBER	POLICY/CLAIM NUMBER	GROUP NUMBER	POLICY/CLAIM NUMBER

PRIMARY INSURANCE POLICY HOLDER	SECONDARY INSURANCE POLICY HOLDER
NAME	NAME
RELATIONSHIP TO INSURED	RELATIONSHIP TO INSURED
DOB	DOB

REFERRING PHYSICIAN

DOCTOR NAME

IN CASE OF EMERGENCY, NOTIFY:

NAME:

PHONE NUMBER:

RELATIONSHIP:

HOW DID YOU HEAR ABOUT ACTION PHYSICAL THERAPY?

PLEASE CHECK ONE

PHYSICIAN	_____	PATIENT	_____	OTHER	_____
FORMER PATIENT	_____	YELLOW PAGES	_____		
FAMILY/FRIEND		NEWS PAPER			

2010

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CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for ***ACTION PHYSICAL THERAPY*** to furnish medical care and treatment to considered necessary and proper in diagnosing on treating his/her physical and mental condition.

I, the undersigned, do authorize ***ACTION PHYSICAL THERAPY***, and staff to leave messages regarding my appointment or health information on my answering machine/voicemail, or with the individual who answers the phone at the numbers indicated on my Information Form or any future contact number I provide. This authorization also gives ***ACTION PHYSICAL THERAPY*** and staff permission to speak to the following spouse, family member, relative or friend regarding, but not limited to, my medical information, treatment, and/or billing:

Name	Relationship	Name	Relationship
_____	_____	_____	_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits, to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to ***ACTION PHYSICAL THERAPY***, and shall be financially responsible for any unpaid balance. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to ***ACTION PHYSICAL THERAPY***.

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal *usual and customary fee schedule,* you will be responsible for the difference remaining.

When you pay by check, you expressly authorize ***ACTION PHYSICAL THERAPY***, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus and applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state allowed recovery fee. In accordance with the rules of the National Automated Cleaning House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that ***ACTION PHYSICAL THERAPY*** cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT. Initial Here: _____

HAWAII STATE TAX

ACTION PHYSICAL THERAPY applies Hawaii State Tax when appropriate. **Your insurance may not cover the tax. If it does not, you are responsible.**

CANCELLATION/NO-SHOW POLICY

I understand that I must give 24 hours notice of cancellation of my appointments, unless extenuating circumstances prevent otherwise. I understand that I, not my insurance company, will be billed $25.00 for same day cancellations or $40.00 fee for No-Show on an appointment. By signing below you are agreeing to all the above terms and conditions.

******The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. **IF WC, PLEASE READ AND INITIAL HERE _____**

INFORMATION PRIVACY

ACTION PHYSICAL THERAPY will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution.

I HAVE READ AND FULLY UNDERSTAND ALL OF THE INFORMATION WITHIN *ACTION PHYSICAL THERAPY* POLICY DOCUMENT AND HEREBY AGREE TO COMPLY AS OUTLINED ABOVE. THE UNDERSIGNED ALSO ACKNOWLEDGES RECEIPT OF THE INFORMATION PRIVACY FORM.

_____ _____

Patient/Guardian/Responsible Party Signature **Date**

_____ _____

Center Representative/Witness Signature **Date**

MEDICAL PROFILE & HISTORY QUESTIONNAIRE

Please fill out the following questionnaire & History as completely as possible. This enables your Physical Therapist to establish a clinical profile upon which a sage and appropriate therapy program is planned. Your input is very important.

Name: _____ Age: _____ Date: _____

Occupation: _____ Hours worked per week: _____

Last date worked due to injury:_____ Date returned to Work_____ Attorney Involved: YES NO

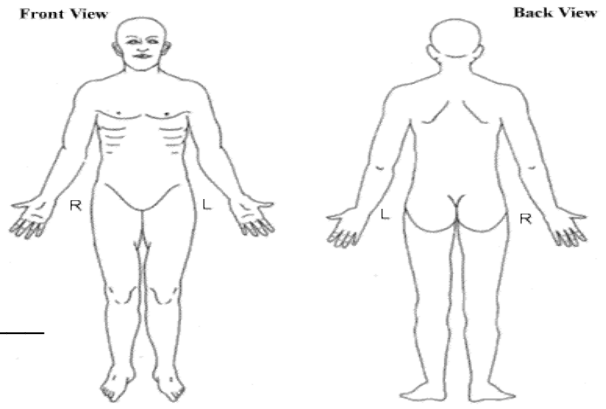
Have you had Surgery for this injury: YES NO Took Place In: Hospital Surgery Center

Type of Surgery:_____ Number of Surgeries: 1 2 3 4 _____

Referring Physician: _____ Date **last** doctor's visit/exam: _____

Family Physician/Internist: _____ Date **next** visit/exam: _____

1. When did this problem/injury Start (On-Set Date)? _____
2. What problem or diagnosis brings you to this Physical Therapy office? _____
   _____
   _____
3. If this was an injury, check the appropriate boxes. Briefly describe how it happened.
   ( ) **Motor Vehicle Accident** ( ) **Work Injury** ( ) **Sports** ( ) **Other, explain below**?
   _____
   _____
4. Shade in on this **body chart** or describe in **words** where you feel your pain or symptoms.
   _____
   _____
   _____



5. On a scale of zero to ten, with zero (0) " **NO PAIN",**
   Ten (10) as the "**WORST PAIN** you can imagine", rate:

   The best it has been: _____ The worst it has been: _____
   Your pain today: _____
6. What makes your pain or symptoms **BETTER**? _____
   _____
7. What makes your pain or symptoms **WORSE**? _____
   _____

8. Are you currently taking any Prescription or Non-Prescription medications? **YES** **NO**

List Medications:

Anti-inflammatory ____
Muscle Relaxers _____ _____
Pain Medications_____

_____

9. Have you had any of the following Medical or Rehabilitative Service for this injury/episode?

	YES	NO		YES	NO
Chiropractor	____	____	CT Scan	____	____
EMG/NCV	____	____	General Practitioner	____	____
Massage Therapy	____	____	MRI	____	____
Myelogram	____	____	Neurologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Physical Therapy	____	____	Podiatrist	____	____
Emergency Room Care	____	____	X-Rays	____	____

Others:_____

10. Do you now have or have you ever had **ANY** of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	Severe or Frequent Headaches	____	____
Shortness of Breath/Chest Pain	____	____	Vision or Hearing Difficulties	____	____
Coronary Heart Disease or Angina	____	____	Numbness or Tingling	____	____
Do you have a Pacemaker?	____	____	Dizziness or Fainting	____	____
High Blood Pressure	____	____	Ringing in your Ears	____	____
Heart Attack or Surgery	____	____	Weakness	____	____
Stroke/TIA	____	____	Weight Loss/Energy Loss	____	____
Blood Clot/Emboli	____	____	Hernia	____	____
Epilepsy/Seizures	____	____	Tuberculosis	____	____
Thyroid Trouble/Goiter	____	____	Allergies	____	____
Anemia	____	____	Any Pins or Metal Implants	____	____
Infectious Diseases	____	____	Joint Replacement	____	____
Diabetes	____	____	Neck Injury/Surgery	____	____
Cancer or Chemotherapy/Radiation	____	____	Shoulder Injury/Surgery	____	____
Arthritis/Swollen Joints	____	____	Elbow/Head Injury/Surgery	____	____
Osteoporosis	____	____	Back Injury/Surgery	____	____
Gout	____	____	Knee Injury/Surgery	____	____
Sleep Problems/Difficulties	____	____	Leg/Angle/Foot Injury/Surgery	____	____
Emotional/Psychological Problems	____	____	Are you/or could you be Pregnant	____	____
Bowel or Bladder Problems	____	____	Do You Smoke?	____	____

11. List any other information that would assist us in your care:_____

_____

_____

12. Are you aware of what your diagnosis is: **YES** **NO**

**** Based upon your awareness, what are your expectations/goal while in this program**? _____

_____

_____

Patient/Guardian/Responsible Party Signature:_____ **Date:**_____