South Kona Physical Therapy

82-6066 Mamalahoa Hwy., Suite #7
Captain Cook, HI 96704
Ph: (808) 323-8123
Fax: (808) 323-8125

Patient Information

Patient Name: _____ DOB: _____

Mailing Address: _____ City/State/Zip: _____

Home/Cell Phone: _____ Emergency Contact: _____

Email Address: _____

Sex: M or F Marital Status: Single Married Other Age: _____ Weight: _____ Height: _____

Occupation: _____ Employed: Full-Time Part-Time Retired Not Working

Employer: _____ Employer Address: _____ City/State/Zip: _____

Date of Injury/Onset of Pain: _____Referring Physician: _____

Related to Accident?: YES or NO If yes, what kind?: AUTO or WORK (please provide insurance/adjuster info)

Insurance Information/Responsible Party **please present front office with insurance cards & ID**

Primary Ins. Carrier Name: _____ Subscriber's Name: _____

SSN and Member ID#: _____ Subscriber's Date of Birth: _____

Secondary Ins. Carrier Name: _____ Subscriber's Name: _____

SSN and Member ID#: _____ Subscriber's Date of Birth: _____

Accident Insurance Carrier Name: _____ Date of Accident: _____

Adjuster's Name/Phone: _____ Claim#: _____

Assignment of Benefits/Authorization to Release Medical Information

I authorize and assign all medical benefits to which I am entitled to at South Kona Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all changes whether or not paid by said insurance in the event my account becomes delinquent and is therefore in default of payment. If my account becomes past due and placed with a collection agency, all collection fees will be added to your balance, which include collection agency's commission, court costs, and interest accrued. I hereby authorize said assignee to release all information necessary to secure payment of said benefits. A copy of this assignment of benefits shall be considered as effective and valid as the original. _____ Initial/Date

Consent of Care & Treatment

I, the undersigned, do hereby agree and give consent to the evaluation and treatment for my condition by the therapists of South Kona Physical Therapy. I understand that the information collected during evaluation and treatment may be helpful to others with my conditions, and I do hereby consent to have that information gathered, studied, and reported for research purposes in a manner that will not divulge my identity. _____ Initial/Date

Cancellation/No Show Policy

South Kona Physical Therapy appreciates a 24 hour cancellation notice call. This will allow others the opportunity to schedule an appointment vacated by your cancellation. A $50 no-show fee will apply for all appointments missed without a 24 hour cancellation notice. Please be advised that the therapist will discharge you from their care and send a discharge note to your referring physician for three consecutive no-show appointments. This fee is not reimbursable by insurance. _____ Initial/Date

By my signature below, I acknowledge that I have read, understand and agree to the terms and conditions stated above.

Patient Signature: _____ Date: _____

****Past Medical History: Name:** _____ **DOB**: _____

Primary Ins. Carrier: _____ Weight: _____ Height: _____ Date of Injury/Onset: _____

What is the reason for your visit?: _____ Current Pain Location: _____

Are you currently seeing any of following?:

___ PCP ___ Physical/Occupational Therapist ___ Chiropractor ___ Massage Therapist ___ Orthopedic Surgeon

Have you had any tests for this condition?: __MRI __CT Scan __XRAY __Blood Test __Nerve Test

Do you have any of the following conditions?:

__ Anemia	__ Diabetes	__Emphysema	__Rheumatoid Arthritis
__Circulation	__Multiple Sclerosis	__High Cholesterol	__Heart Disease
__HIV/AIDS	__Asthma	__High Blood Pressure	__Pacemaker
__Depression	__Epilepsy	__Headaches	__Kidney Diseases
__Thyroid	__Tuberculosis	__Hepatitis	__Stroke (CVA)
__Traumatic Brain Injury	__Vertigo/Dizziness	__Osteoarthritis	__Cancer:_____

Allergies? Y N If yes, what kind? _____ **Pregnant?** Y N Estimated Due Date: _____

Hospitalizations/Surgeries/Injuries:

Date	Surgery/Hospitalization	Reason
_____	_____	
_____	_____	
_____	_____	

Currently symptoms you are experiencing:

__Numbness	__Pain	__Difficulty Walking	__Nausea/Vomiting
__Tingling	__Weakness	__Chills/Sweat	__Chemical/Substance
__Fatigue	__Fever	__Difficulty Sleeping	__Swelling
__Poor Balance/Falls	__Dizziness/Vertigo	__Bowel/Bladder Dysfunction	__Poor Appetite
__Recent Infections	__Hearing Loss	__Weight Loss/Weight Gain	__Difficulty Breathing

What activities make your symptoms worse?

__Driving	__Exercise (during)	__Exercise (after)	__Sitting
__Sneezing	__Bending forward	__Bending backwards	__Coughing
__Standing	__Walking	__Reaching	__Lifting overhead
__Lifting to side	__Ascending/Descending Stairs	__Showering	__Running/Jogging
__Dressing	__Bicycling	__Toileting	__Shifting w/ driving

(Circle your level of pain 0= no pain, 10= emergency room pain)

Current Pain Level	**Pain at Rest**	**Pain Level w/ Activity**
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Are your symptoms getting?: Better Worse Same **Is your pain worse in:** AM PM Mid Day

Please check ALL over-the-counter medications you have taken in the last week:

__Aspirin	__Advil/Motrin/Ibuprofen	__Tylenol	__Laxatives
__Decongestants	__Vitamins/Mineral Supplements	__Antihistamines	__Antacid

Please list ALL prescription medications & dosages with frequencies (pills, skin injections, patches):

_____

What goals do you wish to accomplish with Physical Therapy?

_____

SOUTH KONA 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 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 SKPT 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

Please list and score at least 3 activities that you are unable to perform or have the most difficulty performing due to your chief complaint:

0 = No difficulty 10 = Unable to complete

Name:	Date: / /
1 Sleep through the night	Score:
2 Self-care	Score:
3 Sit	Score:
4 Stand	Score:
5 Walk	Score:
6 Ascend/descend stairs	Score:
7 Lift	Score:
8 Reach	Score:
9 Work tasks	Score:
10	Score:
11	Score:

Please mark areas of pain relevant to your referral: