



Confidential Patient Information

3221 Waiialae Ave
Suite 360
Honolulu, HI 96816
Phone: (808)734-0020
Fax: (808)732-0010
www.kaimukicare.com

Name _____ DOB _____ Age _____
 Address _____ Apt _____ Phone _____
 City _____ State _____ Zip _____ Gender Male Female
 Permanent Address _____ Phone _____
 City _____ State _____ Zip _____ E-Mail _____
 Social Security # - - - D/L # _____ State _____
 Single Married Widowed Divorced Separated

If a minor, parent / guardian name _____

Social Security # - - - DOB - - -

Employer _____ Phone _____
 Address _____ Ext or Dept _____
 City _____ State _____ Zip _____ Hours _____
 Occupation _____ Supervisor _____

Spouse _____ DOB _____ Age _____
 Social Security # - - - Phone _____
 Employer _____ Work _____
 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** _____

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

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other Illnesses |

specify: _____

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** _____



Consent for Care and Treatment

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I, the undersigned, do hereby agree and give my consent for Kaimuki Care 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 Kaimuki Care. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Kaimuki Care 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 Kaimuki Care, you must promptly remit such payment directly to Kaimuki Care.

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

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Dear Patient:

Kaimuki Care 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 808-734-0020.

Kaimuki Care 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



A NOTE TO OUR PATIENTS...

HAWAII STATE TAX

KAIMUKI CARE applies Hawaii State Tax when appropriate. Your insurance may not cover the tax. If it does not, you are responsible.

CANCELLATION POLICY

Our goal at **KAIMUKI CARE** is to provide you with the highest quality of Physical Therapy available. To achieve your rehabilitation goals, we have provided you with a reserved time slot and ask that if you must cancel your appointment, please provide 24 hours notice so that we may schedule another patient for that time.

If you cancel your appointment less than 24 hours before your scheduled time, you will be charged a **\$25.00** fee. Your insurance does not cover this fee and you will be held responsible for payment. Please see below if you are a Workman's Compensation patient.

Patient's Signature

Date

If you are covered under **Workman's Compensation** you will not be assessed a **\$25.00** charge. We are required to notify your physician and case manager of noncompliance with your schedule.

Patient's Signature

Date