EAST OAHU PHYSICAL THERAPY
EOPT Inc.
Kahala to Hawaii Kai...In Aina Haina

East Oahu Physical Therapy
Aina Haina Professional Bldg.
850 West Hind Drive Ste 201
Office: 377-5605 Fax: 377-5604

Patient: (Last Name)	(First Name)	Date of Birth:
Address:	City, State, Zip:	
Cell Phone:	Home Phone:	Who referred you to EOPT?
Email:	Employer or School:	Marital Status:
Name of Insured if other than Self:	Insured's Date of Birth:	Relationship to Patient:

Insurance:	**Authorization #:**	**Visits Authorized:**	**Authorization Valid Dates:**
Auth #:			
Adjuster:			
Phone/Fax:			
Claim #:			
Co-Pay: $ / Co-Ins: %			

DX Code:	**DX Code:**	**EX Code:**	Next MD Visit:

Referring Physician:	Have you had Physical Therapy this year?	Rx #1	Rx #2	Rx #3	Rx #4

1 CP	2 CP	3 CP	4 CP	5 CP
6 CP	7 CP	8 CP	9 CP	10 CP
11 CP	12 CP	13 CP	14 CP	15 CP
16 CP	17 CP	18 CP	19 CP	20 CP
21 CP	22 CP	23 CP	24 CP	25 CP
26 CP	27 CP	28 CP	29 CP	30 CP
31 CP	32 CP	33 CP	34 CP	35 CP

Assignment of benefits: I assign and authorize payment of medical benefits directly to East Oahu Physical Therapy (EOPT). I understand that I am financially responsible for any charges not paid by my insurance company. I promise to pay EOPT in full any outstanding balance in the event my insurance company fails to authorize or reimburse EOPT for services rendered. I understand that verification of benefits does not guarantee payment. I hereby authorize the release of any medical information necessary to process my insurance claim to EOPT. All copies shall be considered as valid as the original. By signing here I acknowledge this and promise to hold harmless EOPT and any representative there and that I also am aware of all HIPAA rules and guidelines that were made avaiable for full review at any point during my therapy.

Signature (Required) **Date**

East Oahu Physical Therapy Policies

Thank you for choosing East Oahu Physical Therapy (EOPT) as your health care provider.

Consent for Treatment

I, the undersigned, hereby agree and give consent to EOPT to furnish care and treatment considered necessary and proper to address my condition.

Deductibles/Percentage pays and/or Co-Payments

I understand that EOPT will prepare insurance forms, and will bill my insurance carrier directly as a courtesy. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Co-payments can be made at time of service or billed to you at the end of services. Patients are responsible for their deductibles. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received.

It is the patient's responsibility to inform EOPT of any changes to their insurance coverage.

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 if I do not show or cancel with less than 24 hours notice. We reserve the right to remove you from the schedule following 2 late cancels or no-show appointments. By signing below you are agreeing to all the above terms and conditions.

Authorization for Assignment of Benefits:

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of EOPT, and shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to the address on file at the insurance carrier.

Authorization for Signature on File and Release of Information:

I, the undersigned hereby authorize the office of EOPT to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photo copy of this authorization shall be valid as an original. I understand that EOPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that EOPT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I have read and fully understand all of the information within EOPT's Policy document and hereby agree to comply as outlined above.

Patient: _____ Date: _____

Signed: _____ Relation to Patient (if different): _____

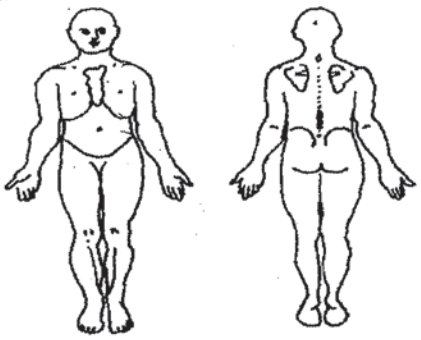
East Oahu Physical Therapy Health History

Name: _____ **Age:** _____

Reason for today's visit/Chief Complaint: _____

PRESENT INJURY/CONDITION

How did symptoms start? When did this start? What makes symptoms worse? What makes symptoms better?	**Please indicate area(s) of symptom on diagram:** Label: (P) Pain (N) Numbness



On a scale of 0-10 (with 10 being severe pain) how would you rate your symptoms?

Please Circle: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

PAST MEDICAL HISTORY: Please indicate (Y) Yes or (N) No if you have had any of the following health concerns.

High Blood Pressure	Y N	_____	Diabetes	Y N	_____
Heart Trouble	Y N	_____	Stroke	Y N	_____
Respiratory Issues	Y N	_____	Tuberculosis	Y N	_____
Weakness of Muscles	Y N	_____	Cancer	Y N	_____
Joint Pain/Stiffness	Y N	_____	HIV	Y N	_____
Numbness/Tingling	Y N	_____	Osteoporosis	Y N	_____
Convulsions/Seizures	Y N	_____	Tremors	Y N	_____
Other	Y N	_____	Head Injury	Y N	

Previous Hospitalization/Surgeries/Serious Illness **When?**

_____

_____

_____

Medication (include nonprescription)

_____

_____

_____

FEMALE PATIENTS ONLY: Are your pregnant? Yes *Due date*_____ No

Patient Social History:

Do you have help at home: Yes: _____ No: _____

Alcohol Use Never: ____ Rarely: ____ Moderate: ____ Daily: ____ How Much? _____

Tobacco Use: Never: ____ Previously, but quit.(when) ____ Current Packs/day: _____

***** TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS CORRECT AND ACCURATE.*****

_____ _____

Patient Signature: Date: