ORTHO SPORT Hawaii

New Patient Intake Form

A. Patient Information

Name: _____ Date:_____

Address: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth: _____ Legal Sex: _____

Who referred you? _____ Primary Care Provider? (Y/N)

Emergency Contact

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Do you have/had any of the following conditions (check all that apply)

- ☐ Heart Attack / Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol / Drug Abuse
- ☐ HIV+ / AIDS
- ☐ Frequent Neck Pain
- ☐ High / Low Blood Pressure
- ☐ Severe / Frequent Headaches
- ☐ Fainting / Seizures / Epilepsy
- ☐ Diabetes / Tuberculosis
- ☐ Lower Back Problems
- ☐ Heart Surgery / Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Venereal Disease
- ☐ Shingles
- ☐ Emphysema / Glaucoma
- ☐ Psychiatric Problems
- ☐ Kidney Problems
- ☐ Sinus Problems
- ☐ Difficulty Breathing
- ☐ Artificial Bones / Joints
- ☐ Heart Murmur
- ☐ Artificial Valves
- ☐ Hepatitis
- ☐ Cancer
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Ulcers / Colitis
- ☐ Asthma
- ☐ Chemotherapy
- ☐ Arthritis
- ☐ Other: _____
- ☐ None of the above

Are you Pregnant? (Y/N) Months? _____

Do you take supplements or vitamins? _____

Do you exercise? What is typical? _____

Are you on a special diet? _____

Do you smoke? (Y/N) If yes, frequency: _____

List any previous serious injuries, surgeries or procedures:

_____

Medications

Medication Name	Dose	Frequency

THE SECTION BELOW IS NOT REQUIRED FOR PERSONAL TRAINING CLIENTS

B. Employment

Employment Status: ☐ Full-time ☐ Part-Time ☐ Unemployed ☐ Retired

Employer: _____

Employer Phone: _____

Primary Insurance

Insured's Name: _____ Date of Birth: _____

Relationship: _____ Employer: _____

Insurance Company:

_____

Insurance Policy Number: _____ Insurance Member ID: _____

Secondary Insurance

Insured's Name: _____ Date of Birth: _____

Relationship: _____ Employer: _____

Insurance Company:

_____

Insurance Policy Number: _____ Insurance Member ID: _____

Reason For Visit

Injury or Major Complaint:

_____

Start Date: _____ Cause: _____

Location of Injury: _____

How would you describe your pain?:

☐ Sharp ☐ Shooting ☐ Dull ☐ Sore ☐ Stiff

What is the current pain rating? (0-10): _____

What is the worst pain rating? (0-10): _____

What is the best pain rating? (0-10): _____

Have you been treated for this injury by (check all that apply)

☐ Doctor ☐ Chiropractor ☐ Acupuncturist ☐ Massage Therapist ☐ Other_____

Your injury interferes with (check all that apply)

☐ Work ☐ Sleep ☐ Daily Routine ☐ None of the above

CONSENT FOR TREATMENT

I consent to have OrthoSport Hawaii, LLC (OSPT) and/or its affiliates to provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

AUTHORIZATION TO RELEASE MEDICAL RECORDS and ASSIGNMENT OF INSURANCE BENEFITS

I authorize OrthoSport Hawaii LLC, or its legal representative, to release to my insurance company or it representative any information including the diagnosis and the records of any treatment or evaluation rendered to me during the period of such care. I hereby authorize payment of medical benefits to which I am entitled to OrthoSport Hawaii, LLC (OSPT) for medical services rendered.

FINANCIAL AGREEMENT and PAYMENT POLICY

I understand that I am financially responsible for all charges whether or not paid by said insurance. These include deductible, co-payment, cost-share, and/or non-covered benefits. In the event of default, I shall be responsible for all costs of collection and reasonable attorney fees. Furthermore, I authorize payment of medical benefits to which I am entitled, to OrthoSport Hawaii, LLC for medical services rendered. I understand that payment is due at the time of service. We accept credit cards, cash, or personal checks.

APPOINTMENT CANCELLATION POLICY & CANCELLATION FEE SCHEDULE

We require 24 hours advance notice for any RESCHEDULE or CANCELLATION of scheduled appointments. This allows us reasonable time to offer your scheduled appointment time to other clients that may be on a wait list. We do have 24 hour answering machines for your convenience during non-working hours, weekends, and holidays.

In fairness to our other clients and staff we do charge a no show/cancellation fee for appointments that are not kept, or which are cancelled with less than 24 hours' notice. No Show/Cancellation fees must be paid in full at the time of your next appointment. Our no show/cancellation fee schedule is as follows:

- **Physical Therapy** patients will be charged a $50 fee for each "no show" or appointment canceled with less than 24 hours' notice. (More than 15 minutes late to your appointment is considered a "No Show")
- **Medical Gym** clients will be charged the full session for missed appointments and late cancellations.

Upon your third no show and/or cancellation with less than 24 hours' notice, your case will be discharged and your physician will be notified of your progress to date and reason for discharge.

Regardless of cancellation fees paid, repeated cancellation or "no show" appointments will limit the therapeutic benefit of treatment. Depending upon your individual case and your particular insurance plan, we may be required to discharge you as a patient and notify your referring physician in the case of repeated cancellations or missed appointments.

I certify that the information I have provided above is correct. I permit a copy of this authorization to be used in place of the original. I authorize OrthoSport Hawaii LLC to send me text/email reminders unless I decline this option verbally or in writing. This authorization is valid until revoked by me in writing.

Patient / Parent / Guardian Signature	Relationship to Patient	Date

By typing your name in the "Patient/Parent/Guardian Signature" space, you agree to the terms indicated on this form.

Printed Name

ORTHOSPORT
physical therapy &
aquatic rehabilitation
www.OrthoSportHawaii.com

Authorization to Share Health Information with Family Members or Friends

(This form does NOT authorize release of copies of the medical chart)

Patient Full Name: _____ Date of Birth: _____/_____/_____
(First) (Middle) (Last)

Many of our patients allow family members such as their parent(s), grandparents, guardians or others to call and discuss their medical/billing information, request prescriptions; vaccine information, medical records and results of tests also pick up forms, etc. Under the requirements of HIPAA we are not permitted to release this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members or friends, you must sign this form.

☐ I decline to have my medical information discussed with family and friends.

☐ I give permission to OrthoSport Hawaii to discuss my health information listed above to the following individuals:

Name _____Relationship_____

Name _____Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

- I understand I must sign a separate authorization form releasing copies of my medical record to another individual.
- I understand I have the right to revoke my permission at any time except where OrthoSport Hawaii has already made disclosures in reliance upon this requests. I understand this this permission remains in effect until the time I revoke in writing.

_____ _____
Signature of Patient/Person Representative Date

_____
Personal Representative/ Relationship to patient

_____
Staff Member Signature

3/15/23dam

ASSUMPTION OF RISK AND RELEASE

There are certain inherent risks with physical therapy, telehealth physical therapy, and personal training sessions as they may require physical exertion, or force applied to the body, along with performance of activities with increasing levels of difficulty. I understand that participation in physical therapy and personal training could potentially cause injury, or increase the pain associated with an injury. I understand that all procedures will be thoroughly explained before performance, and that I will be able to stop treatment at any time if I so choose. I understand that the physical therapist, and other providers will take every precaution to ensure that patients are protected from any potentially hazardous situation.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. Furthermore, I the undersigned, individually and on behalf of the undersigned's heirs, representatives and next of kin, agree to release, waive and discharge, and to indemnify and hold harmless OrthoSport Hawaii, LLC, and its employees and affiliates from any responsibility or liability arising from my participation in physical therapy, telehealth physical therapy, personal training, or the use of the facilities at OrthoSport Hawaii. I am fully aware that I am participating in these sessions at my own risk and will not hold OrthoSport Hawaii LLC, its employees or affiliates responsible in the event of injury or exacerbation of any condition. If I have any medical conditions I have consulted with my physician to make sure that it is appropriate for me to participate in physical therapy.

HIPAA CONSENT: Health Insurance Portability and Accountability Act

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations.
2. The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
3. The practice reserves the right to change the notice of privacy practices.
4. The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The patient also understands that OrthoSport Hawaii, LLC has adopted the following policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters relating to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. We sometimes remind patients of their appointments as a courtesy. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you.

I have read and consent to the assumption of risk and release and the HIPAA practices adopted by OrthoSport Hawaii LLC.
I understand that non-identifying patient data may be used in research and/or publication and consent to such use.

Patient / Parent / Guardian Signature _____ Relationship to Patient _____ Date _____

By typing your name in the "Patient/Parent/Guardian Signature" space, you agree to the terms indicated on this form.

_____

Printed Name