ORTHOSPORT physical therapy & aquatic rehabilitation
www.OrthoSportHawaii.com

Niu Valley - 5722 Kalanianaole Hwy, Lower Level Honolulu, Hawaii 96821
Downtown - 745 Fort Street, #105 Honolulu, Hawaii 96813
Kaka'ako – 400 Keawe St, #102 Honolulu, HI 96813
Phone: (808) 373-3555 (Central Appointments) Fax: (808) 373-3666

Welcome to OrthoSport Hawaii! We're looking forward to seeing you and providing you the best rehabilitation services possible in our state of the art facility located in East Honolulu or at our Downtown location. We offer both aquatic and land based physical therapy services. At our newest location in Kaka'ako we offer land based physical therapy services.

Our Niu Valley clinic is located in the Niu Valley Shopping Center at: **5722 Kalanianaole Highway, Lower Level, Honolulu, Hawaii 96821**. We are located next to Lung Fung and Gyotaku, on the ground floor. If you require a wheelchair and walker friendly entrance, ours is located on the mauka end of the building (near the dumpsters).

Our Downtown clinic is located inside the UNYQE Fitness Center (Basement Level) in the Topa Financial Building at: **745 Fort Street, #105, Honolulu, HI 96813.** We have validated parking for the 1st hour and $1 for one additional hour in the Topa Financial Building. The parking lot entrance is located from Ala Moana Blvd. side of the building. After parking in public parking make your way to the nearest elevators and select the Lobby level (*L). Out of the elevator, turn **Left** and walk into the main breezeway. Stay **Left** to wrap around past the security desk and past the flower shop on your **Left** toward the sign saying "Fort Street Tower" with an arrow. Take a **Left** at the sign following the arrow and continue down the hallway past the elevators. UNYQE Fitness main entrance will be the last door on the **Left** before the Fort Street Tower lobby. Please come down to the front desk and explain you are here for physical therapy and ask to be seen to the OrthoSport Clinic.

Our Kaka'ako clinic is located inside Island Urgent Care at: **400 Keawe Street, #102, Honolulu, HI 96813**. The parking lot entrance is located on 327 Keawe St or on 564 Pohukaina St. Automated parking system. Free parking for the first hour. 2nd hour is $1 with validation. We do validated parking.

Attached are forms that we would like you to fill out prior to your first visit with us so that we can best utilize our evaluation and treatment time with you. Please complete them to the best of your ability and bring them with you to your first appointment.

In addition to the enclosed forms, please bring the following to your first visit:

1. Photo identification.
2. Your insurance card(s) or letter of authorization for your worker's compensation claim.
3. Your physical therapy referral (prescription) from your doctor, unless it was faxed directly to our office.
4. Your calendar. We have a list of patients waiting to begin their therapy with us and would like to schedule as many of your appointments as possible at your first visit to avoid scheduling conflicts and ensure you have the best outcome from physical therapy.

Please come prepared to start your therapy after your evaluation at your first appointment. You should bring loose fitting clothing appropriate for exercise or stretching. If you were referred for aquatic rehabilitation, please bring your swimsuit or clothing that you can wear into the pool and a towel. We have changing areas and showers for your convenience but do not provide towels.

If you have any questions, please don't hesitate to call us at 373-3555.

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WEB: www.orthosport.com

Patient Information

Please review, make necessary changes and supply any missing information.

Patient Information									
First Name:		**Middle Name:**		**Last Name:**					
Date of Birth:		**Gender:**		**Marital Status:**					
Address:		**City:**		**State:**		**Zip:**			

How did you hear about OrthoSport ?	

Contact Information					
Primary Contact # (Choose One)					
☐ **Home Phone #:**		☐ **Work Phone #:**		**Extension:**	
☐ **Cell Phone #:**		**Email:**			

***Would you like to receive appointment reminders by: (Choose Only One) ☐ Voice Call ☐ Text Message ☐ Email

EMERGENCY CONTACT					
Name:		**Relation:**		**Contact #:**	

Guarantor Information					
First Name:		**Last Name:**		**Date of Birth:**	
Relationship:				**Contact #:**	
Address:					

PRIMARY INSURANCE			
Name:		**Group Name:**	
ID #:		**Group #:**	
Phone:			
Insured:		**Date of Birth:**	

FOR WORKERS COMPENSATION (WC)/AUTO INJURY (Auto)					
Employer:(WC)			**Phone:**(WC)		
Employer Address:(WC)					
Insurance Name:(WC/Auto)			**Claim #:**(WC/Auto)		
Date of Injury:(WC/Auto)		**Adjustor:** (WC/Auto)		**Phone:** (WC/Auto)	

SECONDARY INSURANCE			
Name:		**Group Name:**	
ID #:		**Group #:**	
Insured:		**Date of Birth:**	

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:

- $50 fee for each appointment "no show" or cancelled with less than 24 hours' notice. (More than 15 minutes late to your appointment is considered a "No Show")

Initial:_____

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.
This authorization is valid until revoked by me in writing.

Patient / Parent / Guardian Signature	Relationship to Patient	Date

_____
Printed Name

ASSUMPTION OF RISK AND RELEASE

There are certain inherent risks with 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, 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 those named above 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

_____

Printed Name

Medical History Questionnaire

Name: _____ Date: _____

Please fill in the circles completely.

Female o Male o Age: ` Birthdate: _____ Occupation: _____

Have you received assistance from another medical specialist? *Please fill in the appropriate circle.*

	No	Yes (within last 12 months)	Yes (more than 12 months ago)
Acupuncture	o	o	o
Chiropractic	o	o	o
Massage	o	o	o
Naturopath	o	o	o
Osteopath	o	o	o
Other Physical Therapy	o	o	o
Psychologist	o	o	o
Vocational/Rehab Counselor	o	o	o

Other specialist. (*Please list, e.g. Orthopedist, Neurologist*) _____

Do you use an assistive device?

	No	Yes (*Community use only*)	Yes (*Home*)
Single-Point Cane	o	o	o
Quad Cane	o	o	o
Walker	o	o	o
Wheelchair	o	o	o

Other device/explanation. _____

Have you EVER been diagnosed as having any of the following conditions? *Please fill in the appropriate circle.*

	No	Yes	(Month//Year)		No	Yes	(Month//Year)
Lung Cancer	o	o	____/____	Skin Cancer	o	o	____/____
Breast Cancer	o	o	____/____	Bone Cancer	o	o	____/____
Prostate Cancer	o	o	____/____	Leukemia	o	o	____/____
Colon Cancer	o	o	____/____	Lymphoma	o	o	____/____

Other *(please list)* _____

	No	Yes		No	Yes
Kidney infection	o	o	Chronic sinus infection	o	o
Pneumonia	o	o	Pelvic inflammatory disease	o	o
Bone or joint infection	o	o	Chronic urinary tract/bladder infection	o	o

Other infection. (Please list) _____

	No	Yes		No	Yes
Heart attack	o	o	High blood pressure	o	o
Heart valve problems	o	o	Anemic/low blood levels	o	o
Arterial blockage of the legs	o	o	Asthma	o	o
Diabetes	o	o	Emphysema	o	o
Stroke *(including transient ischemic attacks or mini strokes)*	o	o	Deep venous thrombosis *(blood clots in legs)*	o	o

	No	Yes		No	Yes
Chemical dependency *(i.e. alcoholism/drugs/tobacco use)*	o	o	Degenerative Osteoarthritis *(Wear-and-Tear Arthritis)*	o	o
Depression	o	o	Rheumatoid arthritis	o	o
Tuberculosis	o	o	Ankylosis spondylitis	o	o
Hepatitis	o	o	Stomach/duodenal ulcers	o	o
Hypo or low thyroid	o	o	Epilepsy/Seizures	o	o
Hyper or high thyroid	o	o	Endometriosis	o	o
Multiple Sclerosis	o	o	Headaches/Migraines *(>/1/week)*	o	o
Gout	o	o	Urinary incontinence	o	o
Have you had any falls within the last 12 months?				o	o
Other illnesses diagnosed by a physician. *(Please list)*					

	No	Yes *(within last 12 months)*	Yes *(more than 12 months ago)*
Orthopedic/Joint surgery	o	o	o
Coronary bypass	o	o	o
Appendectomy	o	o	o
Gall bladder surgery	o	o	o
Prostate surgery	o	o	o
Caesarian section	o	o	o
Hysterectomy	o	o	o
Other surgeries. (Please list)			

MEDICINE:
Please list ALL medication you take, both prescription and non-prescription. Include NAME of Medicine, FREQUENCY, and DOSAGE. *Please attach a separate page if necessary*.

Do you have any allergies (e.g., medicine, bees)?

Are you retired? No o Yes o
Are you currently working?

o Not working
Last day worked (Month/Day/Year): ____/____/____
Planning to return to work on (Month/Day/Year): ____/____/____

o Working , light duty
Restrictions
Hours working

o Working , full duty

Current Condition Questionnaire

Please describe the problem / condition that brought you to therapy:

_____

_____

How did your problem / condition begin: **Date your condition began:** _____

_____

_____

What are you most hoping to get out of your therapy / activities you would like to return to:

_____

_____

Best time of day: _____ Worst time of day: _____

Activities / positions that make you worse: _____

_____

Activities / positions that make you better: _____

_____

For how many minutes can you perform the following activities comfortably?

Sitting _____minutes Standing _____minutes Walking _____minutes

Circle two numbers below to indicate your pain at it's best and at it's worst over the last few days:
(No Pain) 0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 (Severe pain)

Mark the areas where you feel the described sensations on your body. Use the appropriate symbol. Mark areas of radiation. Include all affected areas related to your current problem.

ACHE: + + + + +

NUMBNESS: = = = = =

BURNING: XXXX

STABBING: / / / / /

PINS AND NEEDLES: # # # # #