Ohana Pacific Rehabilitation Services

One on One Care

970 North Kalaheo Ave
Building A Suite 307
Kailua, HI 96734
(808) 262-1118

PATIENT INFORMATION		**EMAIL ADDRESS:**_____	
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Ohana Pacific Rehabilitation Services. I understand that I am financially responsible for any balance. I also authorize Ohana Pacific Rehabilitation Services to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: _____

_____

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day _____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week _____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week _____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐ YES ☐ NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ YES ☐ NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

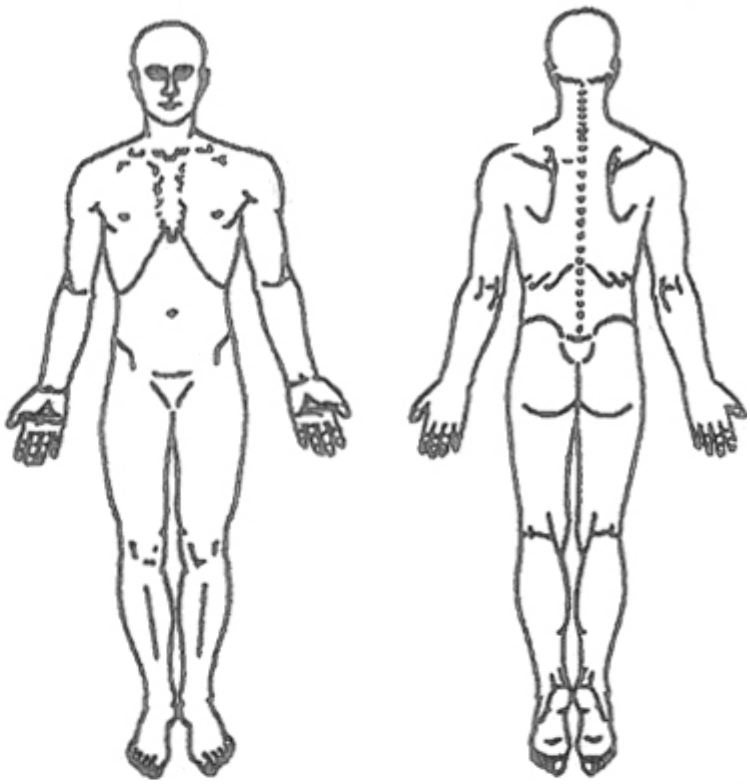
Pain and Symptom Status Report

Name: _____ **Date:** _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
o o o o o o o o o o	/ / / / / /	x x x x
o o o o o o o o	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____
Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your <u>WORST</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments _____

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF USES AND DISCLOSURES
OF PROTECTED HEALTH INFORMATION
FOR

OHANA PACIFIC REHAB SERVICES, LLC

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from Ohana Pacific Rehab Services, LLC a copy of the Notice.

_____
Print Name

_____
Signature

_____
Date

If you would like to receive our newsletter, therapy tips and medical updates, please provide us with your email address below

YES E-mail address _____

NO Thank you.

OHANA PACIFIC REHAB SERVICES, LLC

NOTICE OF THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

TIDS 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 are required by federal Jaw to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. "Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or received by us and relates to your past, present, or future physical or mental health or condition, the provision of health care services to you, or the past, present, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you.

We are required by federal law to comply with the terms of this Notice. We reserve the right to make changes in our privacy practices regarding your Protected Health Information. If we change our privacy practices, that change will apply to all Protected Health Information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes.

We may use and disclose your Protected Health Information for a variety of purposes. For example:

1. Treatment: We may disclose your Protected Health Information to another physician, such as a specialist, to whom we refer you for medical treatment..

2. Health Care Operations: We may disclose your Protected Health Information to a health plan, managed care plan, individual practice association or to a management services organization that analyzes our delivery of medical services to. evaluate our health care quality management, case management or professional compelence. We may also provide your Protected Health Information to other health care providers, such as laboratories or ambulance companies, for purposes of their health care operations.

3. Payment: We may disclose your Protected Health Information to obtain payments. Disclosures for "payment" include: (a) disclosure to a health plan to determine your eligibility or coverage under the plan; (b) disclosures to a health plan to obtain reimbursement for delivering medical Services to you; (c) disclosures to billing services or collection agencies; (d) disclosures for utilization management and determinations of whether the medical services we deliver to you are necessary or appropriate; or (e) disclosures to determine whether the amount we charge you for medical services are justifiable.

4. Reminders and Treatment Alternatives: We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you. This communication may be by telephone call and/or an appointment reminder postcard.

We may use or disclose your Protected Health Information in connection with treatment, payment, or health care operations if we deliver health care products or services to you based on the orde!s of another health care provider, and we report the diagnosis or results associated with the health care services directly to another health care provider, who provides the products or reports to you. We may use or disclose your Protected Health Information that was created or received in emergency treatment situations, to carry out treatment, payment, or health care operations ifwe attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your Protected Health Information without your authorization in the following circumstances: (a) for public health activities, such as controlling communicable diseases, reporting child abuse or neglect, to monitor or evaluate the qualicy, safety or effectiveness of FDA-related products or services; (b) for reporting victims of abuse, neglect or domestic violence; (c) for health oversight activities, such as overseeing government benefit programs; (d) in response to judicial or administrative orders, such as subpoenas; (e) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals; (f) for certain research purposes; (g) to avert a serious threat to the health or safety of an individual or the general public; and (h) for selected governmental functions, such as national security. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was not obtained..

We are required to disclose your Protected Health Information: (a) to you upon your request; and (b) to the U.S. Department of Health and Human Services ("DHHS") when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name. your location in our facility, your general condition and your religious affiliation, if **any,** in **our** facilities directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your Protected Health Information. You will be required to sign an authorization form which permits us to use and disclose your Protected Health Information for certain purposes, and we may not condition the delivery of medical treatment to **you on your providing the requested written authorization. You have the right to revoke your authorization** in **vniting as long as we have not acted** in **reliance on the authorization.**

You have the following rights with respect to your Protected Health Information:

1. The right to request restrictions on our use and disclosure of your Protected Health Information for **treatment, payment or health care operations.** If **we agree to any restriction, then we cannot violate that restriction except** in **the case of emergency treatment. However, we** are **not required to agree to** any **restrictions.**

2. **The right to request** in **writing and to receive confidential communications of your Protected Health Information** by **alternative means (such as by mail or email) or at alternative locations (such as your office or** business workplace).

3. **The right to request in writing access to our office to inspect and copy your Protected Health Information. Except in cases where the Protected Health Information is not maintained or accessible on-site, we will act on a request for access no later than thirty (30) days after we receive your request.**

4. The right to request in writing that we amend your Protected Health Information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after **we receive your request.**

5. The right to receive an accounting of all our disclosures of your Protected Health Information in the six **years prior to the date of your request, except for disclosures: (a) to cany out treatment, payment and health care** operations; (b) to you; (c) for our directory or to persons involved in your care; (d) for national security or **intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written** authorization that you give to us; or (g) that occurred prior to April 14, 2003.

6. The right to request and obtain from us a paper copy of this Notice.

If you believe that we have violated your privacy rights, then you may file a written complaint with Kevin Lockette, who is our privacy officer. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must: (a) be in **writing, either on paper or electronically; (b) name the Company and describe the acts or omissions you believed to be in violation of** the Privacy Rules; (c) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred, unless the time limit is waived by the DHHS for good cause showo. The complaint may be sent to: Office of Civil Rights, U.S. Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco, CA 94102. We will **not retaliate against you for filing a complaint.** If **you wish to obtain additional information about any of the matters discussed** in **this** notice you may contact Kevin Lockette at 808-593-2610.

This Notice is effective as of April 14, 2003.

Ohana Pacific
Rehabilitation Services

354 Uluniu St., #404 Kailua, HI 96734
Phone (808) 262-1118 Fax (808) 262-0045
www.ohanapacificrehab.com

No-Show / Cancellation Policy

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable; however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our one-on-one 60-minute treatments, missed appointments are a significant detriment to your physical therapy, the clinic and other patients.

1. You must provide our office with **24-hour notice** to change or cancel any appointments. Patients who "no-show" a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment will be charged a **$50 dollar fee**.

2. We reserve your one-hour appointment time just for you. We do our best to provide 1:1 optimum treatment outcomes for all our patients. 24-hour notice allows us to place another patient in your cancelled appointment period to received needed treatment.

3. Certain accident claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. After missing two appointments without notice or canceling two appointments in a row, you will also be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance. If canceling or not showing up to your appointments becomes a habit we will notify and transfer your care back to your primary provider.

Thank you for providing our office and our patients with this courtesy.
Signing below indicates you understand and agree to the terms of this policy.

_____

_____ _____
Signature of Responsible Party Date

********** High Quality Physical Therapy on the Windward side (Kailua) **********

****Orthopedic*Neurological*Aquatics*1:1* Continuity of care****