ATTENDANCE POLICY AGREEMENT

Your referring Physician has prescribed a treatment schedule based on: _____ visits per week for _____ weeks or a frequency and duration recommended by your therapist, for optimum recovery. Much of the success of your therapy program is based on your regular and consistent attendance. Therefore, we ask you to schedule your appointments as frequently as your Physician and/or Therapist requests and two weeks in advance is suggested.

If for an unforeseen reason you must cancel an appointment, ***please notify your therapist or our office staff at least 24-hours in advance*** to reschedule your appointment within the same week in order to maintain the prescribed frequency of visits and to allow our therapists the opportunity to adjust their schedule. A $25.00 charge may be assessed if 24-hours advance notice of cancellation is not given and we are unable to fill your dedicated time slot. This fee is not covered by insurance and is payable prior to your next scheduled visit.

Excessive cancellation and no-show appointments may require a return to your physician for an updated prescription. Your cooperation in this matter is sincerely appreciated.

CO-PAY/CO-INSURANCE/DEDUCTIBLE POLICY AGREEMENT

Each and every insurance plan varies in the amounts and type of medical coverage offered. It is between you and your insurance company to understand your benefits. If your insurance company does not cover our services in full, you are responsible for the remaining amount(s) due. If you have any questions, we'd be happy to assist you.

If your insurance plan dictates that you are responsible for an annual deductible and/or co-pay for services rendered, please pay the receptionist or your therapist at time of service. For plans that require a percentage of eligible charges, estimated payments will be accepted. Any under or overage balances will be settled at the time of payment from your insurance carrier. The Elam Sports O`ahu billing department will send out patient statements for any unpaid patient balances on or around the 15th of each month. There is a $15.00 fee for returned checks.

Because of insurance regulations, we are unable to waive co-pays and/or deductibles. If you are unable to meet your financial obligations, please contact our billing department to work out a payment plan. It is your obligation to notify Elam Sports O`ahu of any alterations to your insurance carrier, including policy and benefit changes to ensure proper claim submission.

Co-pay per visit: $ _____ and / or _____ % of eligible charges

Deductible HAS been met: ☐ Deductible has NOT been met: $_____ remaining.

ESO will not be held responsible for inaccuracies in the information received from the insurance company. It is the patient's responsibility to understand and verify their individual benefits.

By signing below, I am acknowledging that I have been informed of Elam Sports O`ahu's attendance and co-pay policies and agree to adhere to the above mentioned policies. I understand that a copy of these statements can be found on the Elam Sports O`ahu website.

_____ _____

Name of Patient (Print) Signature of Patient / Patient Representative

_____ _____

Date Relationship of Patient Representative

Kapolei Clinic · Mobile Therapy Services
91-1027 Shangrila St. Building 1867 Kapolei, HI 96707
Ph: (808) 674-9595 · FAX: (808) 674-9696 elamsportsoahu.com · esoadmin@elamsportsoahu.com

MEDICAL QUESTIONNAIRE

Please fill out the following questionnaire as completely as possible. This will enable your physical therapist to design a safe and appropriate treatment plan for you.

email address

Last Name: _____ First Name:_____ Middle Initial: _____

Age:____ Height:_____ Weight:_____ Occupation: _____ Currently Working: __Yes__No

With who do you currently live? _____

Referring Physician: _____ Date of Next Visit:_____/_____/_____

Family Physician / Internist: _____Date of Last Physical:_____/_____/_____

In case of emergency, whom should we contact? _____ Phone # _____

1. What problem or diagnosis brings you to this Physical Therapy practice? _____
_____

2. Date of Injury:____/___/_____ Is this injury work related? __Yes __No Date of Surgery:_____/_____/_____

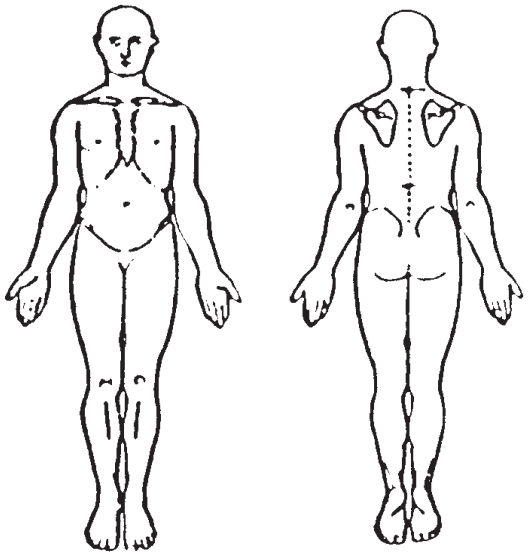
3. Briefly describe how the injury occurred. _____
_____

4. The following test(s) have been completed for this problem: __X-ray __MRI __CAT_____ EMG
__Other_____ __None

5. Have you had this problem before? __Yes__No If YES, describe the past history and what treatment was helpful: _____
_____

6. Describe your pain in words.
_____
_____
_____
_____

Mark the painful areas on the body diagram.



7. Do you have any numbness and/or tingling?
__Yes__No If YES, describe where _____
_____
_____

8. Rate your pain on a scale from 0-10. 0 = NO PAIN and 10 = WORST PAIN you can imagine.

The best it has been since the injury _____
The worst it has been since the injury _____
Your pain today _____

(over)

MEDICAL QUESTIONNAIRE (continued)

9. Is your pain affecting your ability to sleep through the night? __Yes __No _____

10. Does time of day affect your symptoms? __Yes __No _____

11. Does coughing or sneezing increase your symptoms? __Yes __No _____

12. What makes your pain or symptoms BETTER? _____

13. What makes your pain or symptoms WORSE? _____

14. Before the present pain/problem, what exercise(s) were your doing, and how frequently? _____

_____

15. What do you hope to gain from Physical Therapy? _____

_____

16. Functional Status / Activity Level: *(Check all that apply.)*

__Difficulty with bed mobility
__Difficulty with walking
__Difficulty with work/school
__Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
__Difficulty with transfers (such as moving from bed to chair or commode)
__Difficulty with self-care (such as bathing, dressing, eating, toileting)
__Difficulty with recreation or play activity

17. Check if you are **CURRENTLY** taking, or have **RECENTLY** taken any of the following **MEDICATIONS**:

__Steroids (cortisone)
__Heart medication
__Muscle relaxants
__Anti-inflammatory
__Blood pressure medication
__Insulin (diabetes)
__Painkillers
__Anti-coagulants (blood thinners)
__Other_____

_____

_____

18. **I CURRENTLY** have, or have a **HISTORY** of: *(Check all that apply)*

__Cancer/tumors
__Epilepsy/seizures
__Asthma
__Diabetes
__Night sweats
__Hearing problems
__Dizziness
__Bruising easily
__Heart trouble/angina
__Severe pain at night
__Osteoporosis
__High Blood Pressure
__Poor circulation
__Shortness of breath
__Frequent falls
__Thyroid problems
__Blackouts
__Headaches
__Bowel/Bladder problems
__Pacemaker/Nitroglycerin patch
__Chest, abdominal or pelvic surgery
__Major injury to neck/spine/back
__Smoking/Tobacco use
__Coronary artery disease
__Other _____

Additional comments: _____

_____

_____

_____

_____

_____

AUTHORIZATION FOR TREATMENT

I authorize the physical therapists of *ELAM SPORTS O`AHU™* to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. The information provided is accurate to the best of my knowledge.

Signed _____ **Date**_____/_____/_____

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Elam Sports O`ahu Therapy & Training or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Elam Sports O`ahu Therapy & Training may or may not agree to restrict the use or disclosure of your protected health information.

If Elam Sports O`ahu Therapy & Training agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Elam Sports O`ahu Therapy & Training reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Elam Sports O`ahu to use and disclosure my health information in accordance with it.

_____ _____

Name of Patient (Print or Type) Signature of Patient

_____

Date

_____ _____

Signature of Patient Representative Relationship of Patient Representative