James K. Hewson, PT
2228 Liliha St., Suite 407
Honolulu, HI 96817

Honolulu Physical Therapy

Office: 808-526-0507
Fax: 808-523-3096
www.HonPT.com

Insurance Physical Therapy Benefits

Annual Deductible— The annual amount you must pay for services rendered before your health insurance will start making benefit payments.

Annual Deductible: $ _____ Year _____

Co-pay— This is a flat fee paid for a specific service, such as $15 for each office visit.

Estimated co-payment of $_____ due at each visit or _____% due at each visit until deductible is met.

***** Worker's Comp and motor vehicle accident coverage may vary.

Payment is due at the end of each visit.

Personal checks, credit/debit cards, or cash are accepted.

- As a courtesy, Honolulu Physical Therapy will call your insurance company to verify your benefits.
- We assume no liability for errors made by your insurance company in this quote.
- You, the patient, agree to pay any remaining balance after your insurance has paid its portion of the bill.
- Once therapy is complete and final insurance payment is received, any overpayment will promptly be refunded to the patient.

We ask for a 24-hour notice of cancellation of your scheduled appointment.

If Honolulu Physical Therapy is not an "in-network" provider with your insurance carrier there is a chance that the covered benefit checks will be sent from your insurance carrier to you, the patient, rather than to us the provider. The amount of these checks is due to HonPT in addition to any co-pay or co-insurance. We ask that the amount owed is paid promptly for services rendered.

By signing below, you are stating that you understand and accept this responsibility.

Signature _____ Date _____

Staff initials _____

James K. Hewson, PT
2228 Liliha St., Suite 407
Honolulu, HI 96817

Honolulu Physical Therapy

Office: 808-526-0507
Fax: 808-523-3096
www.HonPT.com

Patient Registration Form

***PERSONAL*:**

Name: _____ Phone #: _____
SS#: _____ Cell#: _____
Date of Birth: _____ Address: _____
Ethnic Background: _____ City/State/Zip: _____
Marital Status: _____ Male/Female Email: _____

***EMPLOYMENT*:**

Employer:_____ Work phone #: _____
Occupation: _____ Work status: F/T__P/T__NOT__Retired__

***EMERGENCY CONTACT*:**

Name:_____ Phone #:_____
Relationship to patient: _____

***PRIMARY INSURANCE*:**

WC__ NF__ PRIVATE__ Third Party Liability__

Insurance Carrier:_____ Group #:_____
Policy#: _____ Policy holder SS#: _____
Policy holder IF other than patient: _____ DOB: _____

WORKER COMP/NO-FAULT ADJUSTER INFO:

Name: _____ Phone#: _____
CLAIM#: _____ Fax #: _____

***SECONDARY INSRANCE (IF ANY)*:**

Subscriber Name:_____ Relationship:_____
Insurance: _____ Subscriber DOB: _____
Phone #:_____ _____

REFERRING MD: _____ **CONDITION/INJURY**: _____
Date of onset/injury: _____ _____

Regardless of my insurance coverage. I accept responsibility for all charges incurred during treatment rendered to me.

Signature: _____ Date: _____

James K. Hewson, PT
2228 Liliha St., Suite 407
Honolulu, HI 96817

Honolulu Physical Therapy

Office: 808-526-0507
Fax: 808-523-3096
www.HonPT.com

HIPPA RELEASE

Please review our privacy practices posted in the reception area.

I, _____, hereby authorize Honolulu Physical Therapy (HPT)
(name of patient)

to disclose my health information, including copies of medical records to:

a. any health insurance coverage for me for the purpose of payment of charges

b. any insurance company that provides liability insurance coverage for treating therapist for the purpose of evaluating the treatment rendered to me; or

c. to the treating physician (s) for the purpose of monitoring prescribed treatment and

d. to _____ for the purpose of _____.
(name of person, attorney, etc.)

This authorization shall cover the period of time from my first to last visit.

I understand that I can revoke this authorization at anytime.

SIGNED: _____ DATE: _____

James K. Hewson, PT
2228 Liliha St., Suite 407
Honolulu, HI 96817

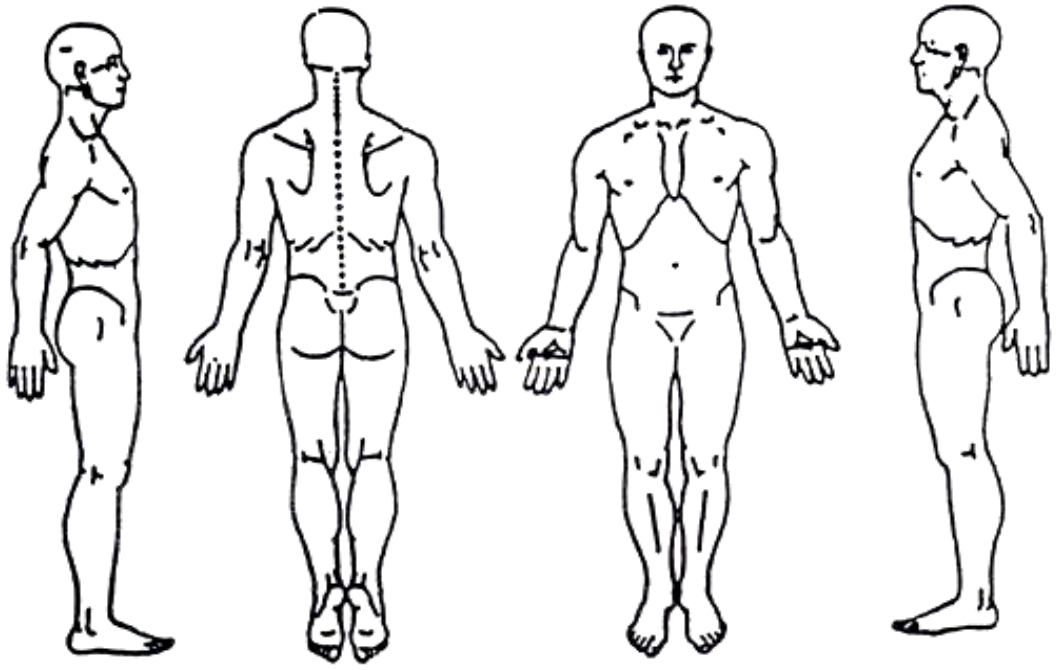
Honolulu Physical Therapy

Office: 808-526-0507
Fax: 808-523-3096
www.HonPT.com

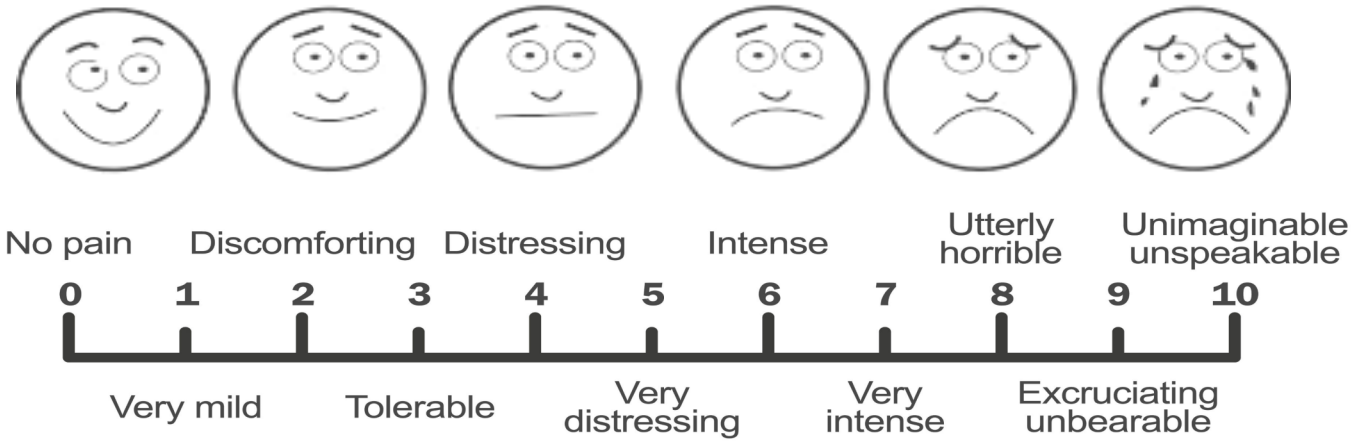
Name: _____ Date: _____

History of Present Condition: _____

Please circle or mark painful or injured areas:



Please mark the number which best represents the severity of your pain over the past 24 hours:



Name: _____ Date: _____

Medicare Patients: Height _____ Weight _____ *Mandatory for reporting BMI to Medicare

Symptoms -What aggravates your symptoms?

____ sitting
____ laying down
____ walking/running
____ up/down stairs
____ reaching overhead
____ lifting objects
____ repetitive activities
____ standing
____ bending forward
____ sleeping
____ turning/twisting body
____ stress
____ playing a sport
____ other: _____

Does anything relieve your symptoms? Please explain: _____
_____

Medications—Please list any current medications, including over the counter supplements:
_____

Past and Current Treatments/Tests—Region of the body and date:

___ Physical Therapy _____
___ Massage Therapy _____
___ Chiropractic Care _____
___ Emergency Room Care _____
___ Hospitalization _____
___ Acupuncture _____
___ CT Scan _____
___ Bone Scan _____
___ X-Rays _____
___ MRI _____
___ Medication _____
___ Injection _____
___ Other _____

History of Present Condition Continued...

___ Asthma
___ Shortness of breath
___ Lung problems
___ Cardiovascular disease
___ Blood clot/Embolism
___ Pacemaker
___ High blood pressure
___ Heart attack
___ Stroke
___ Weakness
___ Loss of balance/falls
___ Dizziness/Fainting
___ Visual difficulties
___ Hearing difficulties
___ Neurological deficits
___ Sleep difficulties
___ Depression
___ Cancer
___ Bowel/Bladder issues
___ Thyroid disease
___ Diabetes
___ Infectious disease
___ Kidney problems
___ Live problems
___ Joint injury: _____
___ Arthritis/Gout
___ Osteoporosis
___ Osteopenia
___ Broken bones/fractures
___ Allergies
___ latex
___ adhesives
___ lotions
___ Pregnant (current/ post--partum)
___ Other _____

Surgery—Please list any previous surgeries (e. g. metal implants, joint replacements, heart, etc.:
_____

Expectations—What are your rehabilitation expectation and goals in this program other than pain reduction? _____

Other—Please list any other information that you believe would assist the therapist in your case:
_____

I, undersigned, certify that the above information described in *History of Present Condition* is true to the best of my knowledge.

Signature of Patient: _____ Date: _____
or Parent/Guardian (if under 18)

James K. Hewson, PT
2228 Liliha St., Suite 407
Honolulu, HI 96817

Honolulu Physical Therapy

Office: 808-526-0507
Fax: 808-523-3096
www.HonPT.com