Hana Pono Appointment Policy and Expectations

Thank you for choosing Hana Pono as your physical therapy provider. We hope you enjoy your time with us and have a positive experience as we help you recover from your injury. In order for us to provide you with the best possible care, we ask that you read the following policies regarding scheduling appointments.

1. **We kindly request that you notify our office at least one business day prior to your scheduled appointment during office hours (8:00 am-5:00 pm, Monday to Friday) if you need to cancel or reschedule.** If someone is not available to take your call, please leave a message.

2. There will be a $60.00 charge for late cancellation/no shows. This fee is necessary because a time commitment is made to you and is held exclusively for you.

3. If a patient has 3 or more “no-shows” or “late cancels”, we reserve the right to cancel all future appointments and move patients to our Standby List. Should you be moved to this list, you will no longer be able to schedule future appointments and must call for same-day appointments. **This includes Medicare and Worker’s Comp/No Fault patients.**

4. Patients who no show/late cancel their initial evaluation will have all future appointments canceled and be referred back to their physician.

5. Estimated deductible and copayments are due upon arrival.

6. If you are sick, including symptoms of COVID-19, we unfortunately will not be able to treat you due to the high risk of infecting other patients and staff members whom you may be in contact with. We hope you recover quickly, and we can resume your appointments when you feel better.

I confirm that I have read, understand, and agree to the above policy

Signature:____Date:______________

Patient Name: ______________________________________

HIPPA NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have been offered a copy for review of Hana Pono Wellness Center's Notice of Privacy Practices which is prominently displayed in the clinic and available on our website (www.hanapono.com).

Our Notice of Privacy Practices provides a description of our treatment, payment activities and healthcare operations as it outlines the use and disclosure of your health information and your rights as a patient. We reserve the right to change our privacy practices in accordance with the law. You may obtain a copy of our Notice or privacy Practices, including any revisions of our Notice, at any time by contacting our office or visiting our website.

Acknowledgement of Receipt

Signature: ____ Date: ___________________

CONSENT TO TREAT & AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize Hana Pono Wellness Center (Hana Pono), through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize Hana Pono or its representative, Medical Professionals Billing to furnish the appropriate agencies for the purpose of billing, any information required, including the diagnosis and records of any examination or treatment rendered to me during my course of treatment.

I hereby assign my therapy benefits to Hana Pono for the services in which I receive and authorize my insurance carrier to make payments to Hana Pono on my behalf. This assignment will remain until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with the collection costs and reasonable attorney fees as may be required to affect collection of this note.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity, and if applicable any information use to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge.

I confirm that I have read, understand and agree to the financial terms stated above.

Signature: ____ Date: ____________________

2 Aarona Place Suite 202, Kailua, HI 96734 Ph: (808) 263-4343

Notice of Privacy Practices

We protect the privacy of our patient's health information by law, practice standards, and our internal policies and procedures. This privacy statement explains your rights, our legal duties, and our privacy practices.

Your Health Information
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We collect, use, and disclose information provided by and about you for medically necessary treatment, health care payment and operations, or when we are otherwise permitted or required by law to do so.

For Treatment: We may use and disclose information about you in providing, coordinating, or managing your treatment and wellness activities. We may provide referring physicians, other providers, and other alternative practitioners information about your treatment when they are appropriately involved with the treatment process.

For Payment: We may use and disclose information about you in managing your medical file, to secure treatment authorization, to confirm insurance coverage, for medical billing and receiving payments for medical care through your health plan or other similar entities. We may also provide information to a doctor's office, hospital, or other health care providers or health plans to confirm your eligibility for benefits, medical diagnosis, treatment, and other medically necessary information in order lo provide appropriate services and receive payment.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you receive; to provide medical file management or coordination of medical services such as between treating therapists or between doctor and therapist.

As Permitted or Required by Law: Information provided by you may be used or disclosed to regulatory agencies, such as during audits, licensure, or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcements official, such as to comply with a court order or subpoena.

Authorization: Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Your Rights: Under regulations that will be in effect on April 14, 2003, you will have additional rights over your health information. Under the new rules, you will have the right to:

- Send us a written request to see or get a copy of information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician or hospital.
- Request additional restrictions on uses and disclosures of your health information. We are not required
- Requestthatwecommunicatewithyouaboutmedicalmattersusingreasonable alternative means or at an alternative address if communications to your home address could endanger you.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment, or healthcare operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

Copies and Changes

You have the right to receive an additional copy of this notice at any time. We reserve the right to revise this no- tice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail.

Contact Information

If you want to exercise your rights under this notice or if you wish to communicate to us about privacy issues or to file a complaint with us, please contact our privacy officer at: (808) 263-4343.

Declaration of Privacy of Health Information

All medical records and other individual identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the US

Department of Health and Human Services (HHS), and are covered by HIPAA (Health Insurance Portability and Accountability Act of 1996).

Further, I authorize that the results of any assessments or records given to me may be used in completing evaluations, assessments, treatment plans, progress reports, summary reports, discharge summary reports and medical billing and reimbursement. I understand that such reports will only report aggregated data, and will only be used for health care purposes such as third party payment and physician or other authorized health care provider treatment or progress reports. I understand I can restrict the uses and disclosures of my medical information. I understand that I have the right to file a formal complaint with a covered provider or health plan or HHS about violations regarding my health and medical records or information.
This release is and shall be binding upon my heirs, assigns, executors, and administrators.
Restrictions requested by patient:

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Signature of Patient:__________________________Date:__________________