



Mana Physical Therapy

"Life Powered By Movement"

68-1845 Waikoloa Road, Ste 211, Waikoloa, Hawaii 96738 •Phone: 808-883-3400 .Fax: 808-883-3440

WELCOME:

Our goal is to help you get back to physical health or help you learn to live successfully with your impairments. We request your cooperation in making this a pleasant experience by following these guidelines:

FRONT DESK:

*If you are financially responsible for your visits, stop at the front desk before leaving.

*Estimated patient portions are to be paid in full at time of each visit. If there is any balance left unpaid by your insurance company, we will send you a statement.

*Please arrive on time for your appointment. Even if you are only a few minutes late, the schedule may be thrown off for subsequent patients. New patients & re-admit patients who completed paperwork at home will need to bring in completed paperwork and arrive 10-15 minutes early. If you need to complete paperwork upon arrival, you will need to arrive 20-30 minutes prior to your scheduled appointment.

*Please bring x-rays and/or medical reports if available

TRACKING YOUR DATES OF SERVICE: (Applies for WC patients or for insurances willing to reimburse a patient). *Keep your appointment printed copies for your records, i.e.: for mileage reimbursement. We are not responsible for compiling these dates.

PATIENT ATTIRE:

Physical Therapy – wear or bring shorts or warm up pants, a loose-fitting shirt, and foot attire safe for exercising (preferably tennis shoes)

Orthotics – wear shorts and shoes appropriate for shoe inserts (not slippers). Shoes cannot be old/broken down. Bring shoe inserts if you have them.

Patients exercising in the gym – you will be exercising with others, so please dress accordingly, and good hygiene is appreciated.

Please notify our staff if you contract any infectious/contagious illness or open wounds, so precautions can be taken to protect you, other patients, and the staff

CHILDREN:

Mana Physical Therapy is not responsible for childcare with patients bringing their children. If your accompanying child is under the age of 9 years old, please provide supervision by another adult. The presence of children can interfere with treatment or pose a safety problem to themselves or others.

Thank you in advance for your kokua!



Mana Physical Therapy

"Life Powered By Movement"

68-1845 Waikoloa Road, Ste 211, Waikoloa, Hawaii 96738 •Phone: 808-883-3400 .Fax: 808-883-3440

INSURANCE:

We accept:	No-Fault Carriers	HMSA Plans	Aetna
	Workers' compensation	BCBS plans	Cigna
	Medicare	UHA	Humana
	United HealthCare	HMAA	Kaiser
	Veterans Administration	Alohacare	Ohana/(Wellcare)
	Tricare	HMA	

Some of these plans require the patient to pay a percentage and copayment plus tax, and/or an annual deductible. **All calculations are estimates only**, and may be subject to additional fees when claims are processed by insurance companies.

Some Aetna, Blue Cross, Private Insurance, and Personal Injury Claims are paid directly to the patient. Payment to Mana PT for these types of coverage must be made at the time of treatment by the patient. We will be glad to file a claim for you if the information provided is complete and accurate. It is your responsibility to know your insurance plan coverage. Mana PT is not responsible for controverted Workers Compensation claims or No-Fault benefits being exhausted. The patient will be responsible for any denied insurance claim and any outstanding charges on their account. We will file only one claim per billing period. If you find out that Mana PT services are covered under another insurance while you are an active patient, Mana PT will bill the insurance for you, and services you paid for will be reimbursed to you after the insurance company renders payment. We will not file a claim if you have been discharged for 3 months, and insurance coverage was pending or not active while a patient at Mana PT.

PAYMENT PROCEDURES:

In order to keep office expenses down and patient costs down, we ask that all Private Pay patients pay at the time of each visit. If your check is returned, a \$25.00 fee will be charged to you. In the event your insurance company denies responsibility for payment, you will become responsible for payment of the balance in full.

If you have secured an attorney regarding a personal injury settlement, payment of medical fees may be tied up in litigation for many months – even years. We are unable to take assignment in these cases and payment will be required at the time of the visit.

A monthly finance charge of 1.5% will be added to your balance after 60 days from the billing date.

NO-SHOW/CANCELLATION:

There is a \$100.00 fee for patients who "No-Show" or cancel an appointment with less than 24-hour notice. If you are 15 minutes or more late to your appointment, your appointment will be canceled and you will be considered a "No Show". All patients are responsible for making up any missed appointments in the same week. If you no-show and do not confirm pre-set appointments, your appointment may be assigned to another patient.

***Patients will need to pay no-show charges at the front desk prior to their next appointment.

QUEST and VA PATIENTS: If you "No Show" or cancel an appointment without giving us a 24-hour cancelation notice any future appointments will be automatically canceled and you will be discharged from care at our facility. We will also notify your referring physician and/or insurance company of your non-compliance.



Mana Physical Therapy

"Life Powered By Movement"

68-1845 Waikoloa Road, Ste 211 Waikoloa, Hawaii 96738 • Phone: 808-883-3400 • Fax: 808-883-3440

Name: _____ Mailing Address: _____
(Last) (First) (MI)

Residence Location: _____

Email Address: _____

Sex: F M Birthdate: _____ Age: _____ Marital Status: M S Social Security #: _____

Ethnicity: Hispanic Pacific Islander Asian African American White American Indian/Alaskan Native Other _____

Primary Phone: _____ Alternate Phone Number: _____ Work: _____

Employer: _____ Occupation: _____

Spouse's name: _____ Spouse's phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referring Physician: _____ Primary Care Physician (PCP): _____

Date of Injury or Onset: _____ Reason for your visit (e.g. body part; weakness or pain) _____

****Are you currently being treated at another P.T. facility?** No Yes, Facility Name: _____

****Is this injury Work Related, a Motor Vehicle/No-Fault Injury or a Third-Party claim?** No Yes

****Is there an attorney assigned to this case?** No Yes: Attorney Name: _____ Phone: _____

Insurance Information: Please list below insurance plan(s) that will cover this disability: IMPORTANT: If insurance billing is requested for our services, the patient is responsible for supplying complete and correct information at the time of treatment. We file only one claim per billing period. Notify us of insurance change. Please check if it applicable: W/C MVI 3P

Claim#: _____ Adjustor: _____ Phone/Fax: _____

Primary Insurance Co.: _____ Address: _____

Subscriber/Relationship: _____ DOB: _____ Policy/Grp #: _____

Private/Other Insurance Co.: _____ Address: _____

Subscriber/Relationship: _____ DOB: _____ Policy/Grp #: _____

Patient Responsibility for PT: Copay/Co-Insurance: _____ Deductible: _____ Patient Initials: _____

I consent to the following: 1) I authorize the above insurance company to pay Mana Physical Therapy, Inc. directly for covered services. 2) I authorize Mana Physical Therapy Inc. to release medical records concerning treatment rendered me to the above insurance company/referral source/PCP. I understand this information will be released only to the above named party(s).

Signature of patient or guardian: _____ **Date:** _____

OFFICE USE: Benefit/Eligibility Notes: _____

Therapist: _____ SOC: _____ DX code 1: _____ Med DX/2: _____ Med DX/3: _____



PAIN QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

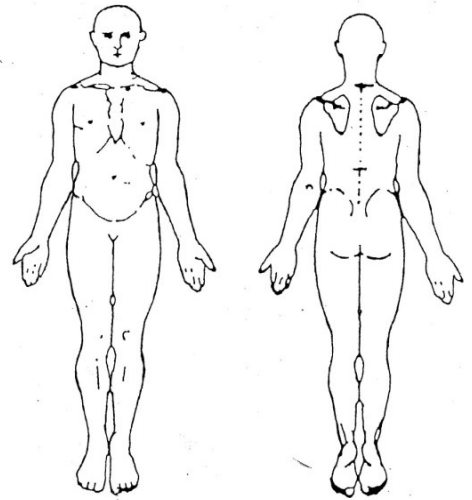
Please complete pain questionnaire: **Where is your pain?** _____ (Please also mark on the chart below)

1. Using the pain scale below, what is the level of your pain at best: _____ Worst: _____
1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (0 is no pain, 10 is the worst pain you can imagine)
2. Did you have an injury? No Yes: Explain what happen and when? _____
3. What positions/activities increase your pain? _____
4. What positions/activities decrease your pain? _____
5. Does the pain awaken you at night? No Yes
6. Are you taking pain meds for this problem? No Yes
7. If you are taking pain medication, what kind of pain meds and how often? _____
What else relieves the pain? _____
8. Do you consider the problem getting better worse?
9. In what way is the problem getting better or worse? _____
10. What Test have you had regarding this problem? (x-ray, MRI) _____
11. Where were these tests taken? _____
12. Have you seen a specialist(s) for this problem? No Yes: Name: _____
13. Are you currently working? No Yes
If yes, how does this problem affect your work? _____
14. Have you had an injury of problem similar to this one before? No Yes If yes, please cite: _____
15. Have you had surgery related to this problem, either current or in the past? _____ If yes, please cite: _____
16. Other comments/concerns you would like us to know: _____

SPINE SECTION (Complete questions 17-22 if your pain is related to the back/neck)

Does the pain radiate into the arms/legs? No Yes (Draw line on picture)

17. Can you get comfortable at night? No Yes
18. What position is most comfortable? _____
19. How is the pain when you awake in the morning? _____ How is the pain when you start moving about? _____
20. How is the pain at the end of the day? _____
21. Do you have headaches No Yes: where do they start? _____
22. Do you have pain with coughing or sneezing? No Yes
23. Other: _____



Therapist Comments

Therapist: _____



"Life Powered By Movement"

68-1845 Waikoloa Road, Ste 211 Waikoloa, Hawaii 96738 • Phone: 808-883-3400 • Fax: 808-883-3440

CONSENT TO TREATMENT

1. I have received a copy of Mana Physical Therapy's welcome letter. I have read the financial policy and I agree to the evaluation and treatment at Mana Physical Therapy, Inc. I further understand that treatment does not imply a guarantee of results and I am willing to proceed with care at Mana Physical Therapy, Inc.
2. I will pay all eligible fees not covered by my insurance company, all collection expenses and \$25.00 fee for any returned checks.
3. I have read the no-show/cancellation policy and accept financial responsibility and/or dismissal from therapy without notice for noncompliance.
4. I understand that my therapist will explain the findings of his/her evaluation and the course of treatment, which will include the modalities/procedures, objectives, expected outcome & precautions.
5. I understand it is my responsibility to ask my therapist questions if I feel I need more information or clarification.
6. I am aware that the support therapy staff, under the direction of the therapist, may be assisting in my care.
7. I understand that if my status undergoing the PT program has not improved or I am inconsistent or noncompliant with scheduled treatment and appointments, the therapist has the right to discharge me from physical Therapy.

CANCELLATION/NO SHOW POLICY

Successful rehabilitation depends not only on the skill of your Physical Therapist, but on the commitment, attendance and efforts of you, the patient, as well! At Mana Physical Therapy we have always prided ourselves on working with our patients in a timely manner so that the therapy process has the most minimal impact on our patients' time. **Any appointment cancelled or rescheduled without a 24-hour notice will be assessed a \$100.00 fee. If you are 15 minutes or more late to your appointment, that appointment will be cancelled and you will be assessed the \$ 100.00 fee.** If you are a Worker's Comp patient, Mana Physical Therapy will notify your workers compensation insurance company and your referring physician of your noncompliance. Our office has set this time aside to accommodate you. Without the proper notice we are unable to provide the opportunity to another patient who may have requested an appointment.

NOTICE OF CONFIDENTIALITY PRACTICES

IMPORTANT: The Health Insurance Portability and Accountability Act (“HIPAA”) is a federal law that sets national standards to protect patient medical records and other personal health information. This notice deals with the sharing of information from your medical records.

Please read it carefully.

This notice describes your confidentiality rights as they relate to information from your medical records and explains the circumstances under which information from your medical records may be shared with others. The information in this notice also applies to others covered under your health plan, such as your spouse or children. If you do not understand the terms for this notice, please ask for further explanation.

YOUR RIGHTS

Under the Health Insurance Portability and Accountability Act, you have the right to:

- Inspect and request copies of your medical reports or to appeal any denial of your request.
- Request that your health care provider append information to your medical reports.
- Receive a notice of your privacy rights by your health plan and/or this office’s practices.

USES OF INFORMATION

This office uses your protected health information to provide you with the health care services. Under the law, your health information may also be used by such entities as health plans for the following purposes:

- Payment to providers who provide you with health care services.
- Conducting quality assurance activities or outcomes assessments.
- Reviewing the competence or qualification of health care professionals.
- Performing accreditation, licensing or credentialing activities.
- Analyzing health plan claims or health care records data.
- Evaluating provider clinical performance.
- Carrying out utilization management/team conferences.
- Conducting or arranging auditing services in accordance with the statute, rule, or accreditation requirements.

Except for the purposes outlined above, your health information may not be disclosed without your authorization

MANA PHYSICAL THERAPY, INC PRIVACY POLICY RELATING TO PATIENT RECORDS

Mana Physical Therapy, Inc. has a policy of protecting patients by restricting access to their individual medical records:

- Insurance companies requesting information regarding treatment of a patient would be restricted to therapy reports and billing information as allowed by the patient, parent, legal guardian or legal representative’s signature on the information sheet.
- Other entities which frequently request records (i.e. physician’s/attorney’s) are also restricted to therapy reports only, and only with a signed authorization for release of medical information signed by the patient, parent, legal guardian or legal representative.
- Verbal communication with insurance companies, case manager, vocational rehabilitation counselors, and care coordinators is restricted to general information regarding compliance with the program and overall progress.
- Access to a patient’s complete medical records is restricted to subpoena only.
- The patient may request a copy of their therapy reports, but will be required to sign a Medical Release form. (Fees for copies apply)
- Records that are sent to us from another healthcare provider such as correspondence, radiographic interpretations, operation reports, etc., are only release upon subpoena. Those individuals requesting these types of records would need to go to the source correspondence or report for a copy.
- Use of cameras, audio video recording and live chat from the patient and companions are strictly prohibited inside the premises of the clinic.



"Life Powered By Movement"

68-1845 Waikoloa Rd., Ste. 211, Waikoloa, Hawaii 96738, (P) 808-883-3400, (F) 808-883-3440

Name: _____ DOB: _____ Date of admit: _____

NOTICE OF CONFIDENTIALITY PRACTICES, CONSENT TO TREATMENT, NO-SHOW/ CANCELLATION POLICY

Please initial below to acknowledge Mana Physical Therapy's:

- _____ Notice of Confidentiality Practices
- _____ Consent to Treatment
- _____ No Show/Cancellation Policy

- I have read, understand, and agree to my confidentiality rights and Mana Physical Therapy's policy regarding my health records stated in the Notice of Confidentiality Practices form.
- I have read, understand, and agree to the terms and guidelines and want to proceed with care at Mana Physical Therapy, Inc.
- I acknowledge that Mana Physical Therapy, Inc. requires 24-hour notice for cancellations. I agree to the No Show/Cancellation policy and want to proceed with care at Mana Physical Therapy, Inc.

Patient Signature: _____ Date _____

DISCLOSURE- (optional)

I give my consent and authorization to Mana Physical Therapy, Inc. to release my protected health information regarding my Physical Therapy treatment, scheduling and/or financial status to the entity/person(s) listed below.

1. Name: _____ Phone: _____ All Medical Information Reports Billing
 Relationship: _____ DOB: _____ Appt/Scheduling Other: _____
2. Name: _____ Phone: _____ All Medical Information Reports Billing
 Relationship: _____ DOB: _____ Appt/Scheduling Other: _____
3. Name: _____ Phone: _____ All Medical Information Reports Billing
 Relationship: _____ DOB: _____ Appt/Scheduling Other: _____
4. Name: _____ Phone: _____ All Medical Information Reports Billing
 Relationship: _____ DOB: _____ Appt/Scheduling Other: _____

This authorization for my medical release of information is in effect from _____. I understand that this authorization will remain in effect until terminated by me in writing.

Patient/Legal Guardian Signature: _____ Date: _____

Mana PT Staff: _____ Date: _____



PATIENT MEDICAL HISTORY (Page 1)

Name: _____ Date: _____

* To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you!

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Leisure Activities: _____

List of Allergies: _____

Are you currently seeing any of the following? Please check that apply.

Medical Doctor Osteopath Dentist Psychiatrist Physical therapy Other _____

Have you ever been diagnosed as having any of the following conditions? (Please check all that apply)

Alzheimer's History of Cancer Progressive neurological deficit

Cardiovascular Disease Huntington's Heart Problem

Cauda Equina Syndrome Immunosuppression Circulation Problem

Cerebral Vascular Accident Lupus Emphysema/Bronchitis

Current infection Muscular Dystrophy kidney disease

Diabetes Type 1 Obesity Epilepsy

Diabetes Type 2 Osteoarthritis Thyroid Problems

Fibromyalgia Parkinson's Other _____

Fracture or suspected Fracture Rheumatoid Arthritis

High Blood Pressure Traumatic Brain Injury

Have you recently noted any of the following? (Please check that apply)

Weight Loss/Weight Gain Weakness

Nausea/Vomiting Fever

Fatigue Numbness

Are you pregnant?

No Yes estimated due date: _____



PATIENT MEDICAL HISTORY (Page 2)

Name: _____ Date: _____

Please list any surgeries or other condition for which you have been hospitalized for, including the approximate date and reason for surgery and hospitalization:

Please described any injuries for which you have been treated for (including fractures, dislocations, sprains) and the approximate date of injury:

Please list of prescription medications you are currently taking including pills, injection and/or skin patches.

Patient or Guardian Signature

Date



Mana Physical Therapy

“Life Empowerment through Balanced Movement”

Kamuela: 65-1230 Mamalahoa Hwy. Ste. E11 Kamuela, Hawaii 96743, (P) 808-885-7131, (F) 808-885-5926

Waikoloa: 68-1845 Waikoloa Rd., Ste. 211, Waikoloa, Hawaii 96738, (P) 808-883-3400, (F) 808-883-3440

Beneficiary Name: _____

Date of Birth: _____

Medicare Number: _____

Today's Date: _____

PATIENT MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mana Physical Therapy, Inc. for any services furnished to me by the physician/supplier, I authorized any holder of Medical information about me to release the Health Care Financing Administrator and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated on the claim form or electronically submitted claims, my signature authorizes releasing the information to the insurance agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the change determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____

NOTICE OF POSSIBLE NONCOVERED SERVICES:

I understand that Mana Physical Therapy, Inc. must be notified if I am currently receiving Home Health Care Services or Hospice services under Medicare, or have been at any time. I also understand that if I begin Home Health Services or Hospice under Medicare while receiving Physical Therapy at Mana PT, I must notify Mana PT. I acknowledge that if I do not notify Mana PT that I am currently/was receiving Home Health Services and/or Hospice, I will be billed for services denied by Medicare.

Patient Signature _____

Date: _____

Witness: _____

Date: _____



Mana Physical Therapy

Kamuela: 65-1230 Mamalahoa Hwy. Ste. E11 Kamuela, Hawaii 96743, (P) 808-885-7131, (F) 808-885-5926
Waikoloa: 68-1845 Waikoloa Rd., Ste. 211, Waikoloa, Hawaii 96738, (P) 808-883-3400, (F) 808-883-3440

Notice of Medicare Cap

Attention: _____ Medicare #: _____

To: All Medicare Subscribers:

Effective January 1, 2018, the Medicare allowed dollar amount for out-patient Physical Therapy and Speech-Language Pathology Services (combined) is \$2010. This means that your benefits for rehabilitation services through Mana Physical Therapy, Inc. will be limited to a cumulative \$2010 of Medicare eligible fees, of which you have a 20% shared responsibility. The part B Medicare deductible for 2018 is \$183.00.

However, as of February 9, 2018, the US senate voted in favor of a bill that permanently repeals Medicare's hard cap for therapy services which now allow you to be covered over the cap of \$2010. Fees beyond the threshold of \$3000 (previously at \$3700) is subject to manual medical review by Medicare. This cap is annual and does not separate facilities, diagnoses or onsets. You need to inform our clinic if you have received any physical therapy or speech therapy **both private or hospital out patient clinics** within the 2018 calendar year so we may assist you in tracking the annual cap. Failure to do so may result in non-coverage, and you may be billed the Medicare eligible fees. If you meet the cap and continue to need therapy, you will be responsible for the Medicare eligible fees.

I have not received Physical Therapy or Speech Therapy this year

I have received Physical and/or Occupational Therapy this year at another facility:

Facility Name: _____

Phone Number: _____

Total number of visits: _____

If I am not eligible for Medicare benefits due to the "cap" having been met at Mana Physical Therapy, Inc. or at another facility, I understand that I may be billed for the services rendered

Patient Signature

Witness

Date: _____