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!

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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:

<u>There is a $100.00 fee for patients who "No-Show" or cancel an appointment with less than 24-hour notice</u>. 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 <u>24-hour cancelation notice</u> 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.

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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: ____________

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PAIN QUESTIONNAIRE

Name: ___________________________________ DOB: _______________ Date: ___________________

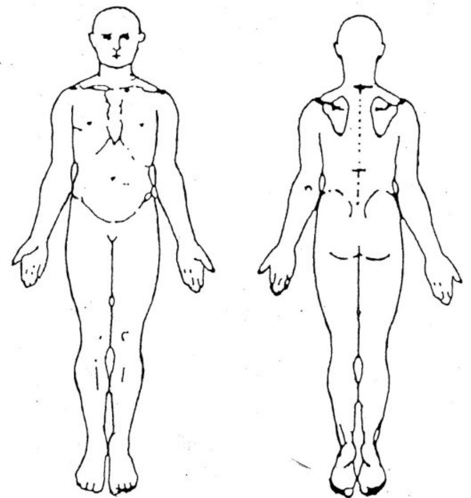
Please complete pain questionnaire: **Where is your pain**? ________________________ (Please also mark on the chart below)

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: ____

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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.

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Name: ________________________________ DOB: ________________ Date of admit: _______________

NOTICE OF CONFIDENTIALITY PRACTICES, CONSENT TO TREAMENT, 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: __________________

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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
__ Cardiovascular Disease
__ Cauda Equina Syndrome
__ Cerebral Vascular Accident
__Current infection
__ Diabetes Type 1
__ Diabetes Type 2
__ Fibromyalgia
__ Fracture or suspected Fracture
__ High Blood Pressure
__ History of Cancer
__ Huntington's
__ Immunosuppression
__ Lupus
__ Muscular Dystrophy
__ Obesity
__ Osteoarthritis
__ Parkinson's
__ Rheumatoid Arthritis
__ Traumatic Brain Injury
__ Progressive neurological deficit
__ Heart Problem
__ Circulation Problem
__ Emphysema/Bronchitis
__ kidney disease
__ Epilepsy
__ Thyroid Problems
__ Other ________________________

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

__Weight Loss/Weight Gain
__Nausea/Vomiting
__Fatigue
__Weakness
__Fever
__ Numbness

Are you pregnant?

__No __Yes estimated due date: ________________

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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