Date:

INTAKE FORM

**I. Personal Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Text?[ ] Yes[ ] No Voicemail? [ ] Yes[ ] No

DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Sex: Male / Female Marital Status: S / M / D / W

Work Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco use: [ ] Yes[ ] No Alcohol use:[ ] Yes[ ] No Vitamin D supplement:[ ] Yes[ ] No

Describe your usual exercise routine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a former IMUA PT patient?[ ] Yes[ ] No A friend/family member/colleague of a former patient?[ ] Yes[ ] No

**II. Medical History:** Have you ever been diagnosed with or do you have any of the following conditions?

(Check all that apply) [ ]  **None of these apply to me**

[ ]  Cancer [ ]  Tuberculosis [ ]  Epilepsy

[ ]  Heart problems [ ]  Sexually transmitted disease/ HIV [ ]  Hepatitis

[ ]  Chest pain/angina [ ]  Rheumatoid Arthritis [ ]  Ulcers

[ ]  Circulation problems [ ]  Arthritis [ ]  Liver problems

[ ] Blood clots [ ]  Bladder/urinary tract infection [ ]  Allergies/asthma

[ ]  Stroke [ ]  Kidney problems/infection [ ]  Pacemaker

[ ]  Anemia [ ]  Cholesterol high/low [ ]  Blood thinners­­­­­­­­­­­­

[ ]  Chemical dependency (i.e. alcoholism) [ ]  Thyroid problems [ ]  Fibromyalgia

[ ]  Depression [ ]  Diabetes [ ]  Broken bones

[ ]  Anxiety [ ]  Osteoporosis [ ]  Recent infection /illness (explain)

[ ]  Lung problems [ ]  Multiple Sclerosis [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past surgical history (list & date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant family medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During the past month have you been feeling down, depressed, or hopeless? [ ] Yes [ ] No

During the past month have you been bothered by having little interest or pleasure in doing things? [ ] Yes [ ] No

Is this something you would like help with? [ ] Yes [ ] Yes, but not today [ ] No

Do you ever feel unsafe at home, or has anyone tried to hit or injure you in any way? [ ] Yes [ ] No

If you are over 65, how many falls have you had in the last 6 months? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications? [ ] Yes [ ] No If yes, please list, or add a list you brought along to this paperwork:

Medication name: Amount: Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. Current Symptoms**

Problem(s) you are here for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What date (roughly) did your symptoms start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you think started your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your symptoms related to a work injury? [ ] Yes [ ] No Or a motor vehicle accident? [ ] Yes [ ] No

Symptoms are currently: [ ]  Getting better [ ]  Getting worse [ ]  Staying about the same

 [ ]  Come and go [ ]  Constant [ ]  Constant, but change with activity

Treatments so far for this problem (injections, chiropractic, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had an X-ray, MRI, or other imaging for this problem? [ ] Yes [ ] No

If yes, please list, including date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had this before? [ ] Yes [ ] No If yes, when and how it was treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your personal goal for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Body chart:** Please mark **all** areas where you feel symptoms

on the chart to the right

What makes your symptoms **better**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What make your symptoms **worse**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How are you able to sleep at night? [ ] Fine [ ] Moderate difficulty [ ] Only with medication

On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:

 0 1 2 3 4 5 6 7 8 9 10

 NO PAIN WORST PAIN

SINCE YOUR SYMPTOMS BEGAN, have you noticed any of the following?

 (Check all that apply) [ ]  **None of these apply to me**

[ ]  Fatigue [ ]  Numbness or tingling [ ]  Fever/chills/sweats

[ ]  Generalized muscle weakness [ ]  Falls [ ]  Nausea/vomiting

[ ]  Pain at night [ ]  Shortness of breath [ ]  Abdominal pain

[ ]  Leg swelling [ ]  Heartburn/indigestion [ ]  Fainting

[ ]  Weight loss/gain [ ]  Difficulty swallowing [ ]  Cough

[ ]  Difficulty maintaining balance when walking [ ]  Headaches [ ]  Chest pain especially with sweats

[ ]  Changes in bowel or bladder function [ ]  Changes in appetite [ ]  Skin changes

[ ]  Changes in cognition [ ]  Heart palpitations [ ]  Other

**IV. How did you hear about our clinic?**

[ ]  My doctor’s office [ ]  I am a former patient [ ]  Family/friend/colleague recommended [ ]  My insurance company said you were in my network [ ]  I did a search on the internet [ ]  My trainer [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tell us who we can thank for sending you our way:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Treatment**

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.

 2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.

 3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.

 4. Worker's Compensation - I hereby authorize IMUA Physical Therapy to receive my records related to my work injury.

**Photo/Video Authorization**

I grant to IMUA Physical Therapy and its affiliated entities, and its representatives and employees (collectively the “Company”) the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation, therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

 ☐ Agree or ☐ Decline

**Notice of Privacy Practices**

By signing this form, I acknowledge that IMUA Physical Therapy has made its’ Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with IMUA Physical Therapy representatives.

**PT Benefits Provided by Your Insurance Company**

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of IMUA Physical Therapy if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment.

In the unlikely event your account would be turned over to a collection agency you would be responsible for all filing, collection, and legal fees necessary to obtain full recovery of any unpaid balance due IMUA PT. There will also be interest added to invoices with balances over 30 days.

I agree to allow IMUA PT to file my Health Insurance should my worker’s compensation, auto, or third-party insurance deny the claim, exhaust the benefits, or fail in any want to pay the claim.

**Release of Information**

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

|  |  |
| --- | --- |
| Name: | Relationship: |
|  |  |
|  |  |

**Authorization**

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

Print Patient Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient or Guardian Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMUA PT Employee Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Authorization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



APPOINTMENT CANCELLATION POLICY

All appointment cancellations must be made 24 hours in advance of your scheduled appointment. This can be done either in person, on the phone, or by leaving us a voicemail at the number listed below. If you do not cancel your appointment 24 hours in advance, or if you do not show for your appointment, you will be charged $50.00 regardless of whether or not you have received reminder(s) from our office.

­­­­­­­­­­­­­­­­­­­­­­Signature Date

**WAILUKU CLINIC: 808. 244. 0077 KIHEI CLINIC: 808. 879. 0077**

*1827 Wells Street #2, Wailuku, HI 96793 411 Huku Li’I Place #101, Kihei, HI 96753*

**LAHAINA CLINIC: 808. 661. 0077 PUKALANI CLINIC: 808. 872. 0077**

*40 Kupuohi Street #105, Lahaina, HI 96761 40 Kupaoa Street B-201, Makawao, HI 96768*

**POLICY DISCLOSURE OVERVIEW**

Imua Physical Therapy (IPT) is pleased to participate in your health care and we look forward to a lasting relationship as your physical therapy provider. In maintaining such a relationship, it is important that expectations, both yours and ours, be clearly communicated. What follows is an explanation of the basic and important steps you must take to ensure our ability to provide you with the services you need. We ask that you read this Policy Statement and ask us any questions you might have. Once you are satisfied with your understanding of this Policy Disclosure, we ask that you sign and date the last page.

**RELATIONSHIP BETWEEN YOU, YOUR INSURER AND IPT**

 Your medical insurance contract is between you, the insured, and your insurance company, the insurance provider. IPT is a medical services provider and as such, we are not a party to that contract. Our contract—and our commitment – is with you as our patient. We can help you understand information about your insurance benefits; however, you are primarily responsible for knowing what type of coverage you have and for any charges that you have incurred under your contract with us as your medical services provider. It is important that you relay any questions or concerns to us in a timely fashion so that we may help you understand and navigate this process.

**CHECKING-IN AND CHECKING-OUT**

Upon arrival to each appointment you must check-in at the front desk, show your insurance card if requested, and make payment if one is due. In accordance with CMS/Medicare guidelines, if you are a Medicare patient, we are required to maintain a record of the time you check-in and check-out with us. If is important for you to know that we treat this sign-in/sign-out record as Protected Health Information (PHI) in accordance with HIPAA regulations.

**CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE AND SELFPAY**

 According to your insurance plan, you are responsible for any and all co-payments, deductibles and co- insurance. We accept cash, checks, & all major credit cards. Our statements satisfy all flexible benefit/health savings account requirements and are available upon request by contacting our office.

**CO-PAYMENTS**

 All co-payments are due at the time of service. If you forget your co-payment for one appointment, please plan to make that payment with your next co-payment upon checking in for your following appointment.

**DEDUCTIBLES AND CO-INSURANCE**

 Deductibles and co-insurance are due within 30 days of receipt of our bill. Some insurance carriers have set allowed amounts for physical therapy visits; in these instances, IPT reserves the right to request the deductible and/or co-insurance payment at the time of service. The front desk can provide a list of known allowed amounts based on the type of insurance. If you participate with a high-deductible health plan ($1,500/year or greater), we require a copy of the health savings account debit/credit card or a personal credit card to remain on file.

**SELF-PAY**

If IPT is not in-network with your insurance carrier and you do not have out-of-network coverage you are responsible for payment in full. Self-pay rates represent the average insurance reimbursement rates for the region; $110/evaluation and $100/follow-up. You may choose to pay for your services rather than go through your insurance, however IPT can’t submit claims to your insurance carrier until a later date. This is due to claim filing limits, time restrictions in obtaining approval & lengthy data entry efforts.

**MEDICAL RECORD FEES**

IPT charges $25 to attorneys for medical records. RETURNED CHECK FEES A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

**INSURANCE**

 Patients must complete and sign information and insurance forms prior to being seen. You must present a current insurance card at each visit if requested. You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days because of information that you have not provided, you will be responsible for payment. If we receive payment at a later date, you will be reimbursed by IPT. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit or visits. If we receive payment at a later date from the correct insurance company, you will be reimbursed by IPT. It is imperative that we receive new insurance as soon as possible so that we can submit our invoices for your visits to your insurance company.

**BILLING**

Patient balances are billed immediately on receipt of your insurance plan’s explanation of benefits. Your remittance is due within 30 days of the receipt of your bill. IPT reserves the right to collect past due balances at the time of service when treating beyond 30 days of your last statement date. Balances over 90 days will be forwarded to a collection agency.

**PROMPT PAYMENT**

Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay our bill promptly. In the case of financial hardship, or if you are unable to pay your bill in its entirety please contact our billing office to discuss payment options. If your account becomes delinquent and you fail to work with us in establishing a payment plan, your account will be turned over to a collection agency.

**MINORS AND DEPENDENTS**

A parent or guardian must accompany all minors (age 17 and under) to the initial evaluation to complete and sign required paperwork. For subsequent visits, patients under the age of 18 may be dropped off for the appointment as long as the Co-payment is paid. Parents and guardians are responsible for payments at the time services are rendered. To aid you in meeting this requirement the billing office can keep a credit card on file. The card will be billed weekly for any payments incurred during the week. Please contact the billing office if you wish to put a credit card on file. The subscriber to an insurance policy will be the party to receive bills from IPT for all dependents on the policy.