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
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ Circulation problems
- ☐Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Depression
- ☐ Anxiety
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Sexually transmitted disease/ HIV
- ☐ Rheumatoid Arthritis
- ☐ Arthritis
- ☐ Bladder/urinary tract infection
- ☐ Kidney problems/infection
- ☐ Cholesterol high/low
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Liver problems
- ☐ Allergies/asthma
- ☐ Pacemaker
- ☐ Blood thinners
- ☐ Fibromyalgia
- ☐ Broken bones
- ☐ Recent infection /illness (explain)
- ☐ 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

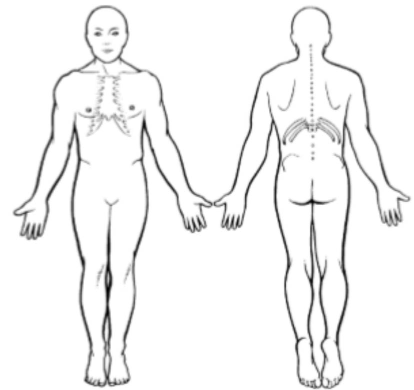
If yes, please list, including date: ____

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 medi

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
☐ Generalized muscle weakness
☐ Pain at night
☐ Leg swelling
☐ Weight loss/gain
☐ Difficulty maintaining balance when walking
☐ Changes in bowel or bladder function
☐ Changes in cognition
☐ Numbness or tingling
☐ Falls
☐ Shortness of breath
☐ Heartburn/indigestion
☐ Difficulty swallowing
☐ Headaches
☐ Changes in appetite
☐ Heart palpitations
☐ Fever/chills/sweats
☐ Nausea/vomiting
☐ Abdominal pain
☐ Fainting
☐ Cough
☐ Chest pain especially with sweats
☐ Skin changes
☐ 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: ____________________________

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; $135/evaluation and $105/follow-up for PT/OT. Massage self-pay rates are $105/45 min, $120/60 min and $150/90 min. 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 $25-50 to attorneys for medical records depending on the amount. 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.

Initial please _____________

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.

Signature ____________________________ Date _________

APPOINTMENT CANCELLATION POLICY

It is extremely important to your recovery process to attend your Physical, Occupational or Massage Therapy appointments. If you are not able to keep your scheduled appointment, please notify us by calling our office no later than 24 hours prior to your appointment. If you get our voicemail, please leave a message. We do check voicemails frequently.

If you are not able to provide 24 hours advance notice, or if you miss your appointment without notifying us, we will charge you $50.00. In addition, we can place you on "same day schedule" status if you no show or cancel more than once. This means that you would not be able to schedule appointments in advance; you would be able to make appointments same day if we have availability. We will notify you prior to placing you on "same day schedule" status.

**Missed appointments: if you miss your appointment and fail to notify us, we will reach out to you. If you do not return the call within 24 hours, we will cancel all of your upcoming appointments you have scheduled in our clinics.

Thank you for your understanding.

____ ____________

Signature ***Date***

Maui Lani Clinic (808)244-0077

118 Ma'a Street Kahului. HI 96732

Lahaina Clinic (808)661-0077

40 Kupuohi Street 105 Lahaina, HI 96761

Kihei Clinic (808) 879-0077

411 Huku Li'I Place Ste. 101 Kihei HI 96753

Pukalani Clinic (808) 872-0077

40 Kupaoa Street B-201 Makawao, HI 96768

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