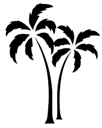

Hawaii Kai Physical Therapy

808-396-8908 · clinic@hawaiikaiphysicaltherapy.com

PATIENT INTAKE AND AUTHORIZATION

Patient Name	Patient Date of Birth	Patient Phone
Patient Address	Patient Email	Referring Physician
Primary Insurance	Policy Number	Prescription Date
Secondary Insurance	Policy Number	Onset Date
Adjuster/Contact for Work. Comp. or Auto Ins. Claim	Estimate of Co-Pay	Deductible

CONSENT FOR CARE AND TREATMENT

I agree to provide a current medical history prior to my initial evaluation and will timely update my health status prior to any treatment by Hawaii Kai Physical Therapy (HKPT). I give my consent for HKPT to furnish medical care and treatment that HKPT deems necessary and proper for my physical condition.

AUTHORIZATION | FINANCIAL RESPONSIBILITY | RELEASE OF INFORMATION

I authorize HKPT to release to my insurance carrier any information needed for the payment of any claim. I authorize payment to HKPT from my insurance carrier or third party payer.

I agree to pay any applicable co-payments, coinsurance, deductibles, and charges for non-covered services at the time of service or as otherwise agreed by HKPT and me. I consent to HKPT securing payment in advance via a credit card authorization. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance carrier or third party payer. If I fail to make payment prior to 30 days after the payment's due date, I will pay a late fee of 1% simple interest per month, and I will pay for all costs of collection, including court costs, collection agency fees, and attorney fees. I will pay a $25 processing fee for each returned check.

Physical and electronic copies of this document are effective and enforceable as originals. I authorize HKPT, to release all information necessary, including medical records, to secure payment. I consent to written electronic communications, including invoicing.

CANCELLATION POLICY

If I cancel a scheduled appointment with less than 24 hours notice, or if I miss a scheduled appointment, HKPT may charge a $35 cancellation fee and may elect not to reschedule the appointment until the fee is paid.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the HKPT Notice of Privacy Practices. I hereby give my consent to HKPT to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. I understand the terms of the Notice of Privacy Practices may change with time. HKPT will post the current Notice of Privacy Practices at the clinic and on HawaiiKaiPhysicalTherapy.com, and HKPT will make physical copies available upon request.

SIGNATURE GIVING CONSENT AND AUTHORIZATION

I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form.

Signature of the Patient, Guardian, or Responsible Party	Date