



ATTENDANCE POLICY AGREEMENT

Your referring Physician has prescribed a treatment schedule based on: _____ visits per week for _____ weeks or a frequency and duration recommended by your therapist, for optimum recovery. Much of the success of your therapy program is based on your regular and consistent attendance. Therefore, we ask you to schedule your appointments as frequently as your Physician and/or Therapist requests and two weeks in advance is suggested.

If for an unforeseen reason you must cancel an appointment, **please notify your therapist or our office staff at least 24-hours in advance** to reschedule your appointment within the same week in order to maintain the prescribed frequency of visits and to allow our therapists the opportunity to adjust their schedule. A \$25.00 charge may be assessed if 24-hours advance notice of cancellation is not given and we are unable to fill your dedicated time slot. This fee is not covered by insurance and is payable prior to your next scheduled visit.

Excessive cancellation and no-show appointments may require a return to your physician for an updated prescription. Your cooperation in this matter is sincerely appreciated.

CO-PAY/CO-INSURANCE/DEDUCTIBLE POLICY AGREEMENT

Each and every insurance plan varies in the amounts and type of medical coverage offered. It is between you and your insurance company to understand your benefits. If your insurance company does not cover our services in full, you are responsible for the remaining amount(s) due. If you have any questions, we'd be happy to assist you.

If your insurance plan dictates that you are responsible for an annual deductible and/or co-pay for services rendered, please pay the receptionist or your therapist at time of service. For plans that require a percentage of eligible charges, estimated payments will be accepted. Any under or overage balances will be settled at the time of payment from your insurance carrier. The Elam Sports O`ahu billing department will send out patient statements for any unpaid patient balances on or around the 15th of each month. There is a \$15.00 fee for returned checks.

Because of insurance regulations, we are unable to waive co-pays and/or deductibles. If you are unable to meet your financial obligations, please contact our billing department to work out a payment plan. It is your obligation to notify Elam Sports O`ahu of any alterations to your insurance carrier, including policy and benefit changes to ensure proper claim submission.

Co-pay per visit: \$ _____ and / or _____ % of eligible charges

Deductible HAS been met: Deductible has NOT been met: \$ _____ remaining.

ESO will not be held responsible for inaccuracies in the information received from the insurance company. It is the patient's responsibility to understand and verify their individual benefits.

By signing below, I am acknowledging that I have been informed of Elam Sports O`ahu's attendance and co-pay policies and agree to adhere to the above mentioned policies. I understand that a copy of these statements can be found on the Elam Sports O`ahu website.

Name of Patient (Print)

Signature of Patient / Patient Representative

Date

Relationship of Patient Representative



MEDICAL QUESTIONNAIRE

Please fill out as completely as possible. This will enable your therapist to design a safe and appropriate plan for you.

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ Height: _____ Weight: _____ Occupation: _____ Currently Working: Y N

Email Address: _____ With who do you currently live? _____

Referring Physician: _____ Date of Next Visit: _____

Family Physician / Internist: _____ Date of Last Physical: _____

In case of emergency, whom should we contact? _____ Phone #: _____

1. What problem or diagnosis brings you to Elam Sports O'ahu? _____

2. Date of Injury: _____ Is this injury work related: Y N _____ Date of Surgery: _____

3. Briefly describe how the injury occurred: _____

4. The following test(s) have been completed for this problem: X-ray MRI CAT EMG None Other: _____

5. Have you had this problem before? Y N _____ If YES, describe the past history and what treatment was helpful: _____

6. Describe your pain in words: _____

7. Do you have any numbness and/or tingling? Y N _____ If YES, describe where? _____

8. Rate your pain on a scale from 0 – 10:

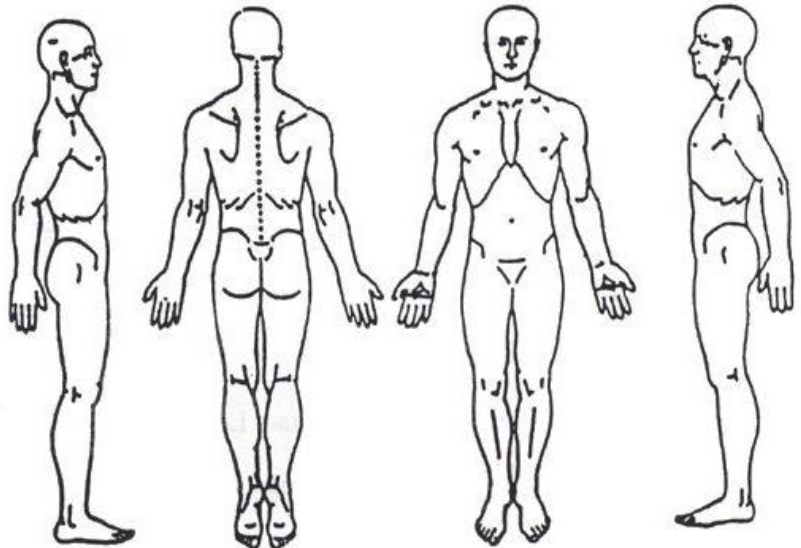
Mark the painful areas on the body diagram:

0 = NO PAIN and **10 = WORST PAIN** imaginable

The best it has been since the injury _____

The worst it has been since the injury _____

Your pain today _____



9. Is your pain affecting your ability to sleep through the night? Y N _____

10. Does time of day affect your symptoms? Y N _____

11. Does coughing or sneezing increase your symptoms? Y N _____

MEDICAL QUESTIONNAIRE (continued)

12. What makes your pain or symptoms BETTER?

13. What makes your pain or symptoms WORSE?

14. Before the present pain/problem, what exercise(s) were you doing, and how frequently? Are you currently exercising, and how often?

15. What do you hope to gain from therapy?

16. Functional Status / Activity Level: (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Difficulty with bed mobility | <input type="checkbox"/> Difficulty with transfers (such as moving from bed to chair or commode) |
| <input type="checkbox"/> Difficulty with walking | <input type="checkbox"/> Difficulty with self-care (such as bathing, dressing, eating, toileting) |
| <input type="checkbox"/> Difficulty with work/school | <input type="checkbox"/> Difficulty with recreation or play activity |
| <input type="checkbox"/> Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents) | |

17. Check if you are **CURRENTLY** taking, or have **RECENTLY** taken any of the following **MEDICATIONS**:

- | | | |
|---|--|---|
| <input type="checkbox"/> Steroids (cortisone) | <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Painkillers |
| <input type="checkbox"/> Heart medication | <input type="checkbox"/> Blood pressure medication | <input type="checkbox"/> Anti-coagulants (blood thinners) |
| <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Insulin (diabetes) | <input type="checkbox"/> Other: |

18. I **CURRENTLY** have, or have a **HISTORY** of: (check all that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Bowel/bladder problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pacemaker/Nitroglycerin patch |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart trouble/angina | <input type="checkbox"/> Frequent falls | <input type="checkbox"/> Chest, abdominal or pelvic surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe pain at night | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Major injury to neck/spine/back |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Smoking/tobacco use |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Coronary artery disease |
| <input type="checkbox"/> Other: | | | <input type="checkbox"/> Currently pregnant, trimester 1 2 3 |
| <input type="checkbox"/> Past surgeries: | | | |
-

Additional comments: _____

AUTHORIZATION FOR TREATMENT: I authorize the therapists of ELAM SPORTS O'AHU to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. The information provided is accurate to the best of my knowledge.

Signed _____ Date _____

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Elam Sports O`ahu Therapy & Training or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Elam Sports O`ahu Therapy & Training may or may not agree to restrict the use or disclosure of your protected health information.

If Elam Sports O`ahu Therapy & Training agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Elam Sports O`ahu Therapy & Training reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Elam Sports O`ahu to use and disclosure my health information in accordance with it.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative