



PHYSICAL THERAPY

69 Railroad Avenue, Suite A4, Hilo, HI 96720

Ph: (808)339-7861 Fax: (808)339-7989

<b>Patient Information</b>				
Last Name:	First Name:	M.I.:	Date of Birth:	Sex: Male      Female
Mailing Address:		E-mail:		
City:		State:	Zip:	
Home Phone:		Mobile Phone:	Work Phone:	
Primary Care Physician:		Employer Name:	Occupation:	
Emergency Contact Name:		Emergency Contact Relationship:		
Emergency Contact Phone Number:		<b>Do you have a workman's compensation or auto case open?</b>		
Please list parties (other than your referring physician) who you grant access to your health information:				

<b>Please fill out guarantor information if other than the patient. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor.</b>		
Last Name:	First Name:	Date of Birth:
Relationship to Patient:		Phone:
Address of Person Responsible:		
City:	State:	Zip:

I have filled this out to the best of my knowledge and will notify the office of any changes.

\_\_\_\_\_ **Print Name**

\_\_\_\_\_ **Signature**

\_\_\_\_\_ **Date**

# Assignment of Benefits (AOB) Form

## Patient Information

Name of Insured (print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Secondary Insurance (if applicable): \_\_\_\_\_

## Authorization & Financial Responsibility

I authorize the payment of insurance benefits (including Medicare, if applicable) directly to **Core Wellness Hawaii Inc. dba 80/20 Physical Therapy & Wellness** (the "Provider") for services provided. I also authorize the release of necessary medical information to:

- The Provider
- CMS (Centers for Medicare & Medicaid Services)
- My insurance carrier
- Other medical entities as required

A copy of this authorization may be sent to my insurer, CMS, or other entities upon request. This authorization remains valid unless revoked in writing.

## Patient Financial Responsibility

I acknowledge that I am financially responsible for **any charges not covered by my insurance**. This includes but is not limited to **deductibles, co-insurance, denied claims, and non-covered services**. It is my responsibility to verify coverage with my insurance provider.

I understand that **WebPT Billing handles all billing inquiries**. Before submitting a dispute to the clinic, I must first contact **WebPT Billing at (800-478-2778)**. If I do not complete this step, my dispute will not be reviewed, and I remain responsible for all charges.

If I am a Medicare beneficiary, I acknowledge that **Medicare does not cover maintenance treatments** and that I am responsible for payment of these services.

Insurance benefits **cannot always be determined upfront**. If my insurance denies payment, I am responsible for any remaining balance as determined by the Provider and/or my insurer.

## HIPAA Compliance & Privacy Notice

By signing below, I confirm that I have reviewed the **Provider's Notice of Privacy Practices** as required by HIPAA.

## Acknowledgment & Signature

Print Name of person signing below: \_\_\_\_\_

Signature (Patient/Guardian): \_\_\_\_\_

Date: \_\_\_\_\_



# Zero Tolerance Late Cancellation / No-Show Policy

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- ***24-HOUR NOTICE IS REQUIRED***

Cancellations must be made **at least 24 hours in advance**.

- ***NO FEES***

Although there is no fee for a late cancellation or no-show, **repeat occurrences will impact your access** to services with our facility.

- ***ONE GRACE***

You are allowed **one late cancellation or no-show without penalty**. (*Providing a reason is not necessary*)

- ***SECOND OCCURRENCE = IMMEDIATE DISCHARGE***

A second late cancellation or no-show will result in **immediate discharge** from physical therapy services and a referral back to your physician.

- ***15 MINUTES LATE = NO-SHOW***

Arriving more than **15 minutes past your scheduled time** will be considered a no-show.

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Our commitment to your care is a shared responsibility. Consistent attendance is essential to achieving your goals. By signing below, I acknowledge that I understand this policy and commit to fully participating in my care. I recognize that my attendance impacts not only my progress but also the team's ability to deliver

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*Updated 1/01/2025*



## **Notice of Privacy Practices**

### **Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used/disclosed and how you can get access to this information. **Please review it carefully.**

#### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

##### **Get a copy of your medical record**

- You can ask to see or get a copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

##### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

##### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

##### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

##### **Get a list of those with whom we’ve shared information**

- You can ask for a list of who we’ve shared your health information to, and why.

## **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

## **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)
- We will not retaliate against you for filing a complaint.

## **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **To Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

## **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

## **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

## **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Changes to the Terms of this Notice**

**We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and in our office. <sup>1</sup>**

Initial \_\_\_\_\_

Date \_\_\_\_\_

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<sup>1</sup> Charles A Wagner, DPT \* 69 Railroad Ave. Ste A4 \* Hilo, HI 96720 \* 808.339.7861  
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