8020
PHYSICAL THERAPY + WELLNESS

69 Railroad Avenue, Suite A4, Hilo, HI 96720 Ph: (808)339-7861 Fax: (808)339-7989

| **Patient Information** | | | | |
|---|---|---|---|---|
| Last Name: | First Name: | M.I.: | Date of Birth: | Sex:<br>▫ Male<br>▫ 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: | | **Do you have a workman's compensation or auto case open?** | | |
| Please list parties (other than your referring physician) who you grant access to your health information: | | | | |

| **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.** | | |
|---|---|---|
| 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**

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## *ASSIGNMENT OF BENEFITS FORM*

Name of Insured (print):_____

Date of birth:_____

□ _____ is my primary insurance

□ _____ is my secondary insurance (leave blank if none)

I request the payment of authorized insurance benefits (including Medicare, if I am a Medicare beneficiary) to be made on my behalf to Core Wellness Hawaii Inc. dba 80/20 Physical Therapy & Wellness (the "Provider") for any services provided to me by the Provider. I authorize the release of any medical or other information necessary to determine the extent of all benefits payable for related equipment or services on my behalf to the (i) the Provider, (ii) the Centers for Medicare and Medicaid Services ("CMS"), (iii) my insurance carrier, (iv) or other medical entity. A copy of this authorization will be sent to CMS, my insurance company, or other entity if requested. The original authorization will be kept on file by the Provider. I understand that this assignment will remain in effect until revoked in writing by me.

I understand that I am financially responsible to the Provider for any charges not covered by health insurance benefits. It is my responsibility to notify the Provider of any changes in my health insurance coverage.

If I am a Medicare beneficiary, I understand that Medicare does not pay for maintenance treatments and that I am responsible for paying for these services out-of-pocket. I also authorize payment of all medical benefits to apply to all occasions for primary and supplemental (Medigap) coverage to be paid to the Provider.

In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my healthcare insurer if the submitted claims or part of them are denied for payment.

I understand that, by signing this form, I am accepting financial responsibility, as explained above, for all payment and services provided by the Provider. By signing this document, I also acknowledge that I have reviewed the Provider's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my rights.

Print name of person signing below:_____

Signature of insured or parent/guardian:_____

Date:_____

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# 24 hour Cancellation / No-Show Policy

***24 hour notice*** *is required for all cancellations.*

*A* ***$50*** ***fee*** *will be implemented for all no-shows and late cancellations/reschedules under the required* ***24 hour notice****.*

*Second occurrence will result in* ***discharge from PT services*** *and referral back to your physician.*

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

For your convenience, additional *details* regarding this policy are *on the back of this page.*

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Patient Signature | Date |

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PHYSICAL THERAPY + WELLNESS

# Comprehensive Late Cancel/Reschedule and No-Show Policy:

At 80/20 Physical Therapy & Wellness, we are committed to providing the highest quality care and service to all our patients. In order to ensure the efficient scheduling and the best possible care for all our patients, we enforce the following Late Cancel/Reschedule and No-Show Policy:

1. **24-Hour Notice**
   Patients are required to provide a minimum of 24-hour notice for any appointment changes or cancellations. This allows us to optimize scheduling and accommodate the needs of all our patients efficiently.
2. **$50 Fee**
   Appointments that are canceled or rescheduled with less than 24-hour notice, or any missed appointments, will be subject to a $50 fee. This fee helps to offset the costs associated with the unused appointment time.
3. **Second Occurrence**
   In the event of a second occurrence of a late cancellation/reschedule or no-show, the patient will be discharged from our services and be subject to our $50 fee. We will then notify your referring physician that services have been terminated and physical therapy services will need to be sought elsewhere.

***We understand that emergencies and unforeseen circumstances can arise. We want to assure you that we will evaluate each situation on a case-by-case basis. Decisions regarding late cancels/reschedules and no-shows will be made with careful consideration of the individual circumstances. We will take into account any emergencies or significant mitigating factors that may have contributed to the late cancel, reschedule, or no-show.***

This policy is enforced to help ensure fair and efficient scheduling for all our patients, while also maintaining the high standards of care and service that we strive to provide. We appreciate your understanding and cooperation in adhering to this policy and thank you for your continued support of 80/20 Physical Therapy & Wellness.

Thank you for entrusting us with your care and for being a valuable part of our patient community.

Sincerely,

80/20 Physical Therapy

# ***Notice of Privacy Practices***

8020 PHYSICAL THERAPY + WELLNESS

## 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/**
- 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**.**

## 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. [1]**

Initial _____

Date _____

[1] Charles A Wagner, DPT * 69 Railroad Ave. Ste A4 * Hilo, HI 96720 * 808.339.7861
charlesaywagner@8020ptandwellness.com