HOLOMUA
PHYSICAL THERAPY
MOVE FORWARD

Confidential Patient Information

Name: _____ **DOB**: _____ **Age**: _____

Gender Identity Male Another identity: _____

Pronouns: He/him/his Another pronoun: _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Cell Phone: _____ **EMail**: _____ *Ok to email?* Y

If minor, parent/ guardian name: _____

Referring Physician: _____

Primary Insurance Company: _____

If not Self, Subscriber's Name: _____ **Subscriber's DOB**: _____

Secondary Insurance Company: _____

If not Self, Subscriber's Name: _____ **Subscriber's DOB**: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

I hereby authorize the release of any personal/ medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignments of benefits.

Signature: _____ **Date**: _____

Patient/Guardian

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Confidential Medical Information

Date of Onset/ Injury / Accident: ☐ Estimated

Please state current problem(s):

Are you currently being treated by:

Medical Specialist: No — Specify::

Another Therapist: No — Or within the last 12 months: No

Chiropractor/ Osteopath: No — Or within the last 12 months: No

Major surgeries since birth:

List current medications:

Check if you currently have or previously had any of the following:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Gout
- ☐ Seizures
- ☐ Stroke
- ☐ Ulcers
- ☐ Other Illnesses

Specify:

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignments of benefits.

Signature: _____ Date:

Patient/Guardian

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Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Holomua Physical Therapy to furnish medical care and treatment to _____, which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature _____ Date _____
Patient/Guardian

Benefit Assignment/ Release of Information

I, the undersigned, hereby assign all medical benefits, ie.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to Holomua Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Holomua Physical Therapy to release all medical information and records necessary to secure payment for services rendered.

Signature _____ Date _____
Patient/Guardian

Financial Policy Statement

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by Holomua Physical Therapy, you must promptly remit such payment directly to Holomua Physical Therapy.

If you are a Workers' Compensation patient, the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/ or a reasonable attorney fee.

I have read the above information and/ or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature_____Date _____
Patient/Guardian

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Patient Privacy Policy & Procedure Statement

Dear Patient:

Holomua Physical Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 808-531-1122.

Holomua Physical Therapy reserved the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

Signature _____ Date: _____

Patient/Guardian

Holomua Physical Therapy No-Show and Cancellation Policy

At Holomua Physical Therapy, our goal is to provide high-quality, individualized care in a timely manner. In order to do so effectively and fairly, we have established the following policy regarding missed appointments, late cancellations, and rescheduling.

1. Appointment Commitment

Your scheduled appointment time is reserved exclusively for you. We do our best to respect your time and ask that you do the same for ours.

2. Cancellations and Rescheduling

We require **at least 24 hours' notice** for cancellations or rescheduling of appointments.

- Cancellations made **less than 24 hours** in advance may be subject to a **cancellation fee of $50**.
- Same-day cancellations and rescheduling attempts are treated as late cancellations.

3. No-Shows

A **no-show** is defined as missing an appointment without any prior notice. No-shows significantly impact our ability to serve other patients.

- **First no-show:** A courtesy reminder of our policy will be given.
- **Subsequent no-shows:** A **$100 no-show fee** will be charged and may result in limitations on future scheduling.

4. Late Arrivals

If you arrive **more than 10 minutes late**, we may need to shorten your session or reschedule, depending on therapist availability. This may also incur a partial or full session charge.

5. Insurance and Fees

Please note that **cancellation and no-show fees are not billable to insurance** and are the responsibility of the patient.

6. Exceptions

We understand that emergencies and unforeseen circumstances arise. Please contact us as soon as possible at (808) 531-1122, and we will evaluate exceptions on a case-by-case basis.

Acknowledgement
By scheduling an appointment with Holomua Physical Therapy, you agree to adhere to this cancellation and no-show policy.

Signature_____ Date_____