CORE Sports
Physical Therapy & Orthopedic Rehabilitation

599 Farrington Highway, Suite 102
Kapolei, HI 96707
Ph: (808) 674-1142 Fax: (808) 674-1143

PATIENT INFORMATION

Please WRITE LEGIBLY and verify that your medical information is updated

Patient's Name:_____
(last name) (first name) (middle Initial)
SSN:_____ Date of Birth_____/____/_____ Gender M F Other

Home Address:_____ Home#_____
(capitalize) (street address, city, state, zip code)

Email Address:_____Cell #_____Work#_____
(capitalize)
Primary Care Physician_____Location_____

Employer and Address_____

WORKER'S COMPENSATION & NO-FAULT INFORMATION

Insurance Name_____Claim #_____
Insurance Adjustor_____Contact #_____
Job Title_____Date of Injury___/___/___
Attorney Name_____Contact #_____

PRIVATE INSURANCE (i.e. HMSA, Medicare, UHA, HMA, Alohacare, etc)

Primary Insurance Company_____Member #_____
Policy Subscriber Name_____Date of Birth___/___/____

Secondary Insurance Company_____Member #_____
Policy Subscriber Name_____Date of Birth___/___/____

Tertiary Insurance Company_____Member #_____
Policy Subscriber Name_____Date of Birth___/___/____

By listing the information and email above, you have authorized CORE Sports Physical Therapy & Orthopedic Rehabilitation and its staff to reach you by these contact numbers, email, and text reminders of your visits. In addition, you give consent to the people below to disclose your patient information.

AUTHORIZED PERSONS FOR PATIENT INFORMATION DISCLOSURE

_____ _____ ___/___/___
(Name) (Relationship) (Date of Birth)

_____ _____ ___/___/___
(Name) (Relationship) (Date of Birth)

_____ _____ ___/___/___
(Emergency Contact Name) (Relationship) (Date of Birth)

_____DATE___/___/___
(Patient signature to consent to the above notice)

❑ **Check the box if you OPT OUT OF TEXT REMINDERS and INITIAL HERE_____**

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APPOINTMENT AND FACILITY POLICIES

1. Please schedule as many appointments ahead of time to meet your requests.
2. Appointment times are often a premium with other motivated patients wanting to get in at the same time. If need be, please call the clinic to reschedule or cancel your visit **AT LEAST 24 HOURS IN ADVANCE in order to avoid the $50 cancellation fee.**
3. If a patient has 2 no show or cancellations in a row, or if a patient has inconsistent attendance during any given treatment plan, his/her doctor and corresponding insurance adjustor will be notified and further action may be taken concerning availability of physical therapy and/or massage therapy.
4. Being late more than 10 minutes may require you to reschedule or wait for the next available opening.
5. **ESTIMATED** COPAYS and DEDUCTIBLES are due upon arrival. Please ask for a handout of billing procedures and protocols for greater clarification.
    a. COPAYS = Estimated amounts that your insurance company expects you to pay out of pocket for each healthcare service. Your healthcare plan that you signed up for, has a certain amount that you pay and a certain amount that your insurance pays. After the copay is made, we bill your insurance company of each service; based on your health insurance plan, they will cover all or a portion of it.
    b. COINSURANCE= Estimated percentage cost towards your health care bill. You start paying your coinsurance after you paid your deductible.
    c. DEDUCTIBLE= how much you pay for your healthcare service before your health insurance pays for anything. For some insurances, you may also have a copay or coinsurance.
6. We reserve the right to charge the individual patient/guarantor for bounced checks with a $30 fee
7. Children requiring supervision are NOT allowed to attend sessions with you. If any disturbance is caused to other patients or staff members you may be asked to terminate the session early and attend to your child.
8. If you are sick or have a severe cold, we unfortunately are unable to treat you at this time due to the high risk of infecting other patients and staff members. Please recover quickly and we can resume your appointment sessions when you feel better.
9. Our facility is equipped with cameras for security purposes and surveillance in our main areas. Please be advised that by continuing with our services, you are giving consent to being treated knowing this.
10. Because of the nature of services provided, you may be asked to disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Always communicate with your therapist should you feel uncomfortable or embarrassed; you may refuse the procedure, and alternate options can be accommodated.

FINANCIAL RESPONSIBILITY AND MEDICAL AWARENESS

I understand and confirm that the use of the services from CORE Sports Physical Therapy and Orthopedic Rehabilitation (CSPTO) is voluntary and I am obligated to ensure payment in full of my fees. I am responsible for understanding my health insurance policy and I am aware of being financially responsible for all charges whether or not paid by insurance. If my insurance denies any part of my bill from CSPTO, I will be responsible to pay my balance in full, including deductibles, copays, and coinsurances. I authorize CSPTO to release any requested medical information or records to any person, organization, or agency, which may be liable for payment of any portion of CSPTO fees and charges. I authorize CSPTO to furnish the attorney that I have retained to represent me for the personal injuries I previously sustained, for which CSPTO is now treating me, with any medical information or records pertaining to me. This includes but not limited to examination, plan of care treatments, progress reports, and daily notes. If I am delinquent for paying my balance, I understand that I will also be responsible for the collection fees of a minimum of $25.

Rev DEC 19

_____DATE___/___/___

(Patient signature to consent to the above policies and notices)