599 Farrington Highway, Suite 102
Kapolei, HI 96707
725 Kapiolani Boulevard, Suite C103
Honolulu, HI 96813
Ph: (808) 674-1142 Fax: (808) 674-1143

## PATIENT INFORMATION

Please WRITE LEGIBLY and verify that your medical information is updated to ensure proper billing

**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** (IT'S VERY IMPORTANT TO VERIFY YOUR PRIMARY VS. SECONDARY!)

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 Analysis, CORE Sports Physical Therapy & Orthopedic Rehabilitation, and CORE Sports Honolulu LLC 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 be advised that our facility has strict COVID-19 procedures; your compliance will contribute to the best safety protocols to other patients and staff members.
2. You are responsible for scheduling your appointment times. 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 late cancellations in a row, or if a patient has inconsistent attendance during any given treatment plan, their doctor may be notified to discuss the continued plan of care for our services. If there is a worker's compensation or no-fault insurance adjustor on the case they may also be notified.
4. Being late may not guarantee your full session beyond your scheduled time. Thus, if you're going to be late, please inform the front desk so your therapist can adjust your treatment plan of care.
5. **ESTIMATED** COPAYS/COINSURANCES and DEDUCTIBLES are due upon arrival. Please ask for a handout of billing procedures, protocols and out of pocket expenses for greater clarification as it can definitely be confusing. Billing information can be found on our website www.coresportshawaii.com.
6. We reserve the right to charge the individual patient/guarantor for bounced checks with a **$30 fee**.
7. Children accompanying patients are allowed, but please be courteous to others while in the gym area. If any disturbance is caused to other patients or staff members you may be asked to terminate the session.
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 inquire about the latest COVID-19 rules as well. Please recover quickly, and we can resume your appointment sessions when you feel better.
9. Our facilities are 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 to address the injured areas. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the therapists. Always communicate with your therapist should you feel uncomfortable, and we can modify accordingly.
11. We are so grateful for our patients who help support CORE Sports Hawaii on social media. But, due to healthcare privacy laws please **avoid taking pictures and videos of other patients**.
12. Please make sure to inform our administrative staff if your **health insurance has changed** to avoid out of pocket expenses.

**FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT AND MEDICAL AWARENESS**

I understand and confirm that the use of the services from CORE Sports Analysis LLC, CORE Sports Physical Therapy and Orthopedic Rehabilitation and/or CORE Sports Honolulu LLC (CORE) is voluntary; I am responsible for understanding my health insurance policy and obligated to ensure payment in full of my fees.

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 I will be responsible to pay my balance in full, including deductibles, copays, and coinsurances.(NOTE: Worker's compensation insurances do not apply if there is a valid authorized prescription)

I authorize CORE to release any requested medical information or records to any person, organization, or agency, which may be liable for payment of any portion of CORE fees and charges.

I authorize CORE to furnish the attorney, who I have retained, 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.

BY SIGNING BELOW, I HAVE UNDERSTOOD ALL OF THE RULES AND POLICIES ON THIS PAGE AND GIVE MY CONSENT TO CONTINUE SERVICES.

________________________________________________DATE_______________

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

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**WAIVER AND RELEASE FORM**

CORE Sports' mission is to promote and further the safety and health of all patients, guests, and employees. In an effort to honor our mission, we require all patients to complete this waiver and release prior to receiving treatment. Please feel free at any time to ask our medical receptionist questions or if you need further clarification.

1. **Identifications of Risks:** I recognize and assume full responsibility that CORE's services and equipment may require physical exertion and I am fully aware of the risks and hazards involved in physical therapy, including, but not limited to: (1) aggravation of pre-existing conditions (2) bodily and/or physical injury; (3) disease; 4) strains; (5) fractures; (6) partial and/or total paralysis, (7) death or other ailments that, could cause serious disability. While participating in CORE's services, if I observe anything unsafe or hazardous, I will stop services and inform my therapist and/or management.
2. **Assumption of Risk**: I obtained medical clearance from my healthcare provider to receive CORE's services. I am physically and psychologically ready to use CORE's facility. I am voluntarily, knowingly and willingly receiving CORE's services.
3. **Waiver and Release**: I voluntarily and expressly waive any claim I may have against CORE and its employees for injury or damages that I may sustain as a result of participating in any services. I, on behalf of myself, my personal representatives & my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, & indemnify CORE Sports Analysis LLC and CORE Sports Honolulu LLC, their representatives & employees from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of service or otherwise which may arise out of my use of any equipment or participation in these activities.
4. **Consent for Patients Who Are Minors**: I am the legal guardian of the patient. I authorize and give my consent for the patient to attend CORE's appointments independently.
5. **Notice of Privacy Practices**: By signing below, I have read CORE's Notice of Privacy Practices and give consent to the use and disclosure of my personal health information by this office for treatment, billing, payment and healthcare operations and the rest of the terms provided. This includes facsimile (fax) transmittal of my medical records, if necessary. If I would like a copy of this notice, I acknowledge that I can ask the office for a copy.
6. **Electronic Signature:** You represent and warrant that the individual electronically agreeing to the terms of these rules, policies, and notices is authorized and empowered to give consent and agree on your behalf. You further agree clicking the "AGREE" button and/or performing any other similar electronic affirmation constitutes an electronic signature as defined by the Electronic Signatures in Global and National Commerce Act and that this agreement is completely valid, has legal effect, is enforceable, and is binding on and non-refutable by you.
7. **Summary:** I authorize CORE's therapeutic staff to perform the appropriate respective services for the care, injuries or ailments that I am here for. I certify that I have read the above waiver and release and that any questions that I had about its content have been answered to my full satisfaction. I freely give my informed consent to both the performance of CORE's services and the consent to release my information as above stated.

PRINT PATIENT NAME__________________________FULL SIGNATURE_____________________DATE_______

PARENT GUARDIAN/GUARANTOR
NAME______________________________FULL SIGNATURE_______________________________DATE_______