ATTENDANCE POLICY AGREEMENT

Your referring Physician has prescribed a treatment schedule based on: _____ visits per week for _____ weeks or a frequency and duration recommended by your therapist, for optimum recovery. Much of the success of your therapy program is based on your regular and consistent attendance. Therefore, we ask you to schedule your appointments as frequently as your Physician and/or Therapist requests and two weeks in advance is suggested.

If for an unforeseen reason you must cancel an appointment, ***please notify your therapist or our office staff at least 24-hours in advance*** to reschedule your appointment within the same week in order to maintain the prescribed frequency of visits and to allow our therapists the opportunity to adjust their schedule. A $25.00 charge may be assessed if 24-hours advance notice of cancellation is not given and we are unable to fill your dedicated time slot. This fee is not covered by insurance and is payable prior to your next scheduled visit.

Excessive cancellation and no-show appointments may require a return to your physician for an updated prescription. Your cooperation in this matter is sincerely appreciated.

CO-PAY/CO-INSURANCE/DEDUCTIBLE POLICY AGREEMENT

Each and every insurance plan varies in the amounts and type of medical coverage offered. It is between you and your insurance company to understand your benefits. If your insurance company does not cover our services in full, you are responsible for the remaining amount(s) due. If you have any questions, we'd be happy to assist you.

If your insurance plan dictates that you are responsible for an annual deductible and/or co-pay for services rendered, please pay the receptionist or your therapist at time of service. For plans that require a percentage of eligible charges, estimated payments will be accepted. Any under or overage balances will be settled at the time of payment from your insurance carrier. The Elam Sports O`ahu billing department will send out patient statements for any unpaid patient balances on or around the 15th of each month. There is a $15.00 fee for returned checks.

Because of insurance regulations, we are unable to waive co-pays and/or deductibles. If you are unable to meet your financial obligations, please contact our billing department to work out a payment plan. It is your obligation to notify Elam Sports O`ahu of any alterations to your insurance carrier, including policy and benefit changes to ensure proper claim submission.

Co-pay per visit: $ _____ and / or _____ % of eligible charges

Deductible HAS been met: ☐ Deductible has NOT been met: $_____ remaining.

ESO will not be held responsible for inaccuracies in the information received from the insurance company. It is the patient's responsibility to understand and verify their individual benefits.

By signing below, I am acknowledging that I have been informed of Elam Sports O`ahu's attendance and co-pay policies and agree to adhere to the above mentioned policies. I understand that a copy of these statements can be found on the Elam Sports O`ahu website.

_____ _____

Name of Patient (Print) Signature of Patient / Patient Representative

_____ _____

Date Relationship of Patient Representative

Kapolei Clinic
91-1027 Shangrila St. Building 1867 Kapolei, HI 96707
Ph: (808) 674-9595 · FAX: (808) 674-9696 elamsportsoahu.com · esoadmin@elamsportsoahu.com

MEDICAL AND INSURANCE REIMBURSEMENT RELEASE

RELEASE OF INFORMATION: I authorize **Elam Sports, Inc. DBA Elam Sports O'ahu** to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that **COPAYMENT IS DUE AT THE TIME OF SERVICE** (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to **Elam Sports, Inc. DBA Elam Sports O'ahu** if this matter is referred to collection.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Name of Patient (Print)	Signature of Patient
Date	
Signature of Patient Representative	Relationship of Patient Representative

v2023

Kapolei Clinic
91-1027 Shangrila St. Building 1867 Kapolei, HI 96707
Ph: 808-674-9595 · FAX: 808-674-9696 elamsportsoahu.com

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Elam Sports O`ahu or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Elam Sports O`ahu may or may not agree to restrict the use or disclosure of your protected health information.

If Elam Sports O`ahu agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Elam Sports O`ahu reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Elam Sports O`ahu to use and disclosure my health information in accordance with it.

_____ _____
Name of Patient (Print or Type) Signature of Patient

_____
Date

_____ _____
Signature of Patient Representative Relationship of Patient Representative

MEDICAL QUESTIONNAIRE

Please fill out as completely as possible. This will enable your therapist to design a safe and appropriate plan for you.

Last Name: First Name: Middle Initial:

Age: Height: Weight: Occupation: Currently Working: Y N

Email Address: With who do you currently live?

Referring Physician: Date of Next Visit:

Family Physician / Internist: Date of Last Physical:

In case of emergency, whom should we contact? Phone #:

1. What problem or diagnosis brings you to Elam Sports O'ahu?

2. Date of Injury: Is this injury work related: Y N Date of Surgery:

3. Briefly describe how the injury occurred:

4. The following test(s) have been completed for this problem: X-ray MRI CAT EMG None Other:

5. Have you had this problem before? Y N If YES, describe the past history and what treatment was helpful:

6. Describe your pain in words:

7. Do you have any numbness and/or tingling? Y N If YES, describe where?

8. Rate your pain on a scale from 0 – 10:

0 = NO PAIN and **10 = WORST PAIN** imaginable

The best it has been since the injury _____

The worst it has been since the injury _____

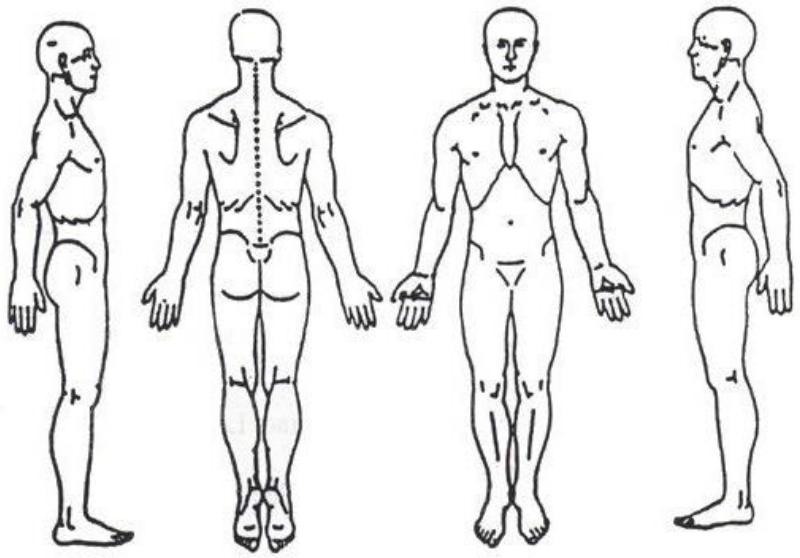
Your pain today _____

9. Is your pain affecting your ability to sleep through the night? Y N

10. Does time of day affect your symptoms? Y N

11. Does coughing or sneezing increase your symptoms? Y N

Mark the painful areas on the body diagram:



(over)

MEDICAL QUESTIONNAIRE (continued)

12. What makes your pain or symptoms BETTER?

13. What makes your pain or symptoms WORSE?

14. Before the present pain/problem, what exercise(s) were you doing, and how frequently? Are you currently exercising, and how often?

15. What do you hope to gain from therapy?

16. Functional Status / Activity Level: (check all that apply)

_____ Difficulty with bed mobility _____ Difficulty with transfers (such as moving from bed to chair or commode)
_____ Difficulty with walking _____ Difficulty with self-care (such as bathing, dressing, eating, toileting)
_____ Difficulty with work/school _____ Difficulty with recreation or play activity
_____ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

17. Check if you are **CURRENTLY** taking, or have **RECENTLY** taken any of the following **MEDICATIONS**:

_____ Steroids (cortisone) _____ Anti-inflammatory _____ Painkillers
_____ Heart medication _____ Blood pressure medication _____ Anti-coagulants (blood thinners)
_____ Muscle relaxants _____ Insulin (diabetes) _____ Other:

18. I **CURRENTLY** have, or have a **HISTORY** of: (check all that apply)

___ Cancer/tumors ___ Dizziness ___ Poor circulation ___ Bowel/bladder problems
___ Headaches ___ Bruising easily ___ Shortness of breath ___ Pacemaker/Nitroglycerin patch
___ Asthma ___ Heart trouble/angina ___ Frequent falls ___ Chest, abdominal or pelvic surgery
___ Diabetes ___ Severe pain at night ___ Thyroid problems ___ Major injury to neck/spine/back
___ Night sweats ___ Osteoporosis ___ Hearing problems ___ Smoking/tobacco use
___ Blackouts ___ High blood pressure ___ Epilepsy/seizures ___ Coronary artery disease
___ Other: _____ ___ Currently pregnant, trimester 1 2 3
___ Past surgeries: _____

Additional comments: _____

AUTHORIZATION FOR TREATMENT: I authorize the therapists of ELAM SPORTS O'AHU to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. The information provided is accurate to the best of my knowledge.

Signed _____ Date _____