Hawaiian Rehabilitation Services, Inc.

CREDIT UNION PROFESSIONAL PLAZA 75-165 Hualalai Road • Kailua-Kona, HI 96740
Phone: 808-329-0591 • Facsimile: 808-329-2066 • Web: http//www.HawaiianRehab.com

Patient:____ Date of Birth_____________________Age___________
Mailing address____
Residence location(if different)_________________________________email address______________________________
Gender:________________ Marital status:_________________ Social Security no___________________________________
Ethnicity___Hispanic____Pacific Islander____Asian____African American____Caucasian____Native American___other_________
Phone : Home____________________cell_______________________work________________emergency________________
Nearest relative/emergency contact:____
Occupation____Referring provider:_______________________________________
Date of onset of symptoms or injury___________________Symptoms/injury area_______________________________L/R______
Insurance coverage: 1)______________________________Policy no_________________________Subscriber____________
Subscriber's DOB/relationship to pt _________________________Ins co address______________________________________
2)(Secondary filed as courtesy only)_____________________________Policy no/subscriber______________________________
Adjustor______________________________/Employer____

INITIAL ALL BELOW AFTER READING. ONLY MEDICARE PTS NEED TO INITIAL THOSE IN ( )

_____I will notify HRS of any insurance policy/coverage changes prior to timely filing limit or I will be 100% financially responsible.
_____I understand my coverage/limitations/deductible__________copay____________(final to be determined upon claim processing)
_____I have/have not received services before at Hawaiian Rehabilitation Services, Inc./when________________________________
_____I have/have not received services for this injury at this or another facility/where____
_____I have/have not obtained or may obtain legal counseling for this injury/who____
_____I have read the general and financial policies of HRS and agree to proceed with evaluation and treatment. Cancellations less than 24 hr in advance of appointment/not made up same week- $45 for initial visit/$25 for subsequent visits.
_____I agree to pay all eligible fees not covered by the above primary insurance company, all collection expenses and returned check fees.
_____I authorize the above insurance company(ies) to pay HRS directly for services covered services.
_____I authorize HRS To release medical records concerning my treatment to the above name party(ies).
_____ I decline auxiliary aids to receive treatment at HRS inc interpreter or assistance services.______________________________
(____) Annual Medicare CAP notification. I will need to notify HRS if I have received any rehab services this year. I understand I may be billed the Medicare eligible fees if I have been notified of the CAP limit or exceeding medical necessity for services.
(____) Hospice and Home Health. I understand that I may not be covered if at any time I receive Hospice or Home Health care while a patient at HRS. This only applies to Medicare insurance.
(____)I have been given the notice for release of medical records and understand that I may revoke approval at any time. Any information we request, such as phone numbers, emails, addresses, will be confidential. Any health records are only released by your consent. Insurance companies listed are allowed information necessary for claims processing/payment.
_____I accept responsibility to participate in my program including regular attendance, performing tasks/exercises instructed in, communicate concerns to the therapist, and following program instructions. If, at any time, the HRS professional determines that I have not improved, do not meet medical necessity for care, am not participating safely/appropriately, or if am demonstrating risks in terms of behavior/illness, poor response, or lack of compliance, I understand that I may be placed on hold or discharged from care at HRS. In this event, my referring provider/insurance company will be notified of my discharge. I will respect the staff and patients of HRS with proper behavior, attire, hygiene and promptness. I will comply with HRS policy regarding attendance by family, minors, pets/service animals, use of cell phones, eating in the facility, smoking or other requests.
_____Other stipulations____

Signature of patient____________________________________Name/signature of guardian/POA__________________________________
Date___________________________ Witness____

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_____I have been informed of the findings of the evaluation/assessment, the plan of care, expected outcome, goals, and precautions. I understand the risks which may be associated with my treatment, expected benefits of treatment, anticipated timeframes/goals, reasonable alternatives to treatment, use of appropriate supportive personnel for treatment and supervision of my therapy program. Risks that may be associated with treatment for this condition include:_____pain____joint noise____swelling____stiffness______tearing of soft tissue________ _____sensorychanges/numbness____weakness/fatigue____subluxation_______fracture_______dizziness/faintness______bleeding/infection_____ nausea_____rash/skin irritation______fall_____other ________Therapist:____________________Patient:______________________________