



# **SOUTH SHORE** PHYSICAL THERAPY, LLC

## **CONSENT FOR CARE AND TREATMENT**

I, the undersigned, do hereby agree and give my consent for **SOUTH SHORE PHYSICAL THERAPY, LLC** to furnish medical care and treatment to \_\_\_\_\_ considered necessary and proper in diagnosing his/her physical and condition.

\_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Date

## **BENEFIT ASSIGNMENT/RELEASE OF INFORMATION**

I authorize any and all insurance companies that I utilize to make payments directly to **SOUTH SHORE PHYSICAL THERAPY, LLC**. I authorize the release of any and all medical information by telephone, fax, or letter which may be needed to process claims and facilitate reimbursement to **SOUTH SHORE PHYSICAL THERAPY, LLC**.

\_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Date

## **FINANCIAL POLICY STATEMENT**

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal **usual and customary fee schedule**, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to **SOUTH SHORE PHYSICAL THERAPY, LLC**.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check, you expressly authorize **SOUTH SHORE PHYSICAL THERAPY, LLC**, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that **SOUTH SHORE PHYSICAL THERAPY, LLC** cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

**Information Privacy:** **SOUTH SHORE PHYSICAL THERAPY, LLC** will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

**I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

\_\_\_\_\_  
Patient/Guardian/Responsible Party

\_\_\_\_\_  
Date

SOUTH SHORE PHYSICAL THERAPY, LLC  
1221 Kapiolani Blvd. Suite 730 • Honolulu, HI 96814  
808.596.2333 • fax 808.596.4545  
www.southshorephti.com

# SOUTH SHORE PHYSICAL THERAPY, LLC

## PATIENT MEDICAL HISTORY

Name: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Date of first visit for this injury: \_\_\_\_\_  
 Last date worked due to this injury: \_\_\_\_\_ Date returned to work after this injury: \_\_\_\_\_  
 Is an Attorney involved in this case?    YES    NO

Have you had Surgery for this injury?    YES    NO                      Number of Surgeries:    1    2    3    4  
 Type of Surgery: \_\_\_\_\_                      Took place in:    Hospital    Surgery Center

Are you currently taking any prescription or non-prescription medications?    YES    NO  
 Anti-inflammatories \_\_\_\_\_    Muscle relaxers \_\_\_\_\_    Pain medication \_\_\_\_\_  
 List medications: \_\_\_\_\_

Are you allergic to any medications?    YES    NO    List medications: \_\_\_\_\_

Have you had any of the following Medical or Rehabilitative Services for the injury/episode?

	YES	NO		YES	NO
Chiropractor	_____	_____	CT Scan	_____	_____
EMG/NCV	_____	_____	General Practitioner	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Myelogram	_____	_____	Neurologist	_____	_____
Occupational Therapy	_____	_____	Orthopedist	_____	_____
Physical Therapy	_____	_____	Podiatrist	_____	_____
Emergency Room Care	_____	_____	X-Rays	_____	_____
Other: _____					

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	Severe or frequent headaches	_____	_____
Shortness of breath/chest pain	_____	_____	Vision or hearing difficulties	_____	_____
Coronary Heart Disease or Angina	_____	_____	Numbness or tingling	_____	_____
Do you have a pacemaker?	_____	_____	Dizziness or fainting	_____	_____
High blood pressure	_____	_____	Bowel or bladder problems	_____	_____
Heart Attack or Surgery	_____	_____	Weakness	_____	_____
Stroke/TIA	_____	_____	Weight loss/Energy loss	_____	_____
Congestive Heart Disease	_____	_____	Hernia	_____	_____
Blood clot/emboli	_____	_____	Varicose Veins	_____	_____
Epilepsy/seizures	_____	_____	Allergies	_____	_____
Thyroid Disease or Goiter	_____	_____	Any pins or metal implants	_____	_____
Anemia	_____	_____	Joint replacement surgery	_____	_____
Infectious Diseases	_____	_____	Neck injury/Surgery	_____	_____
Diabetes	_____	_____	Shoulder injury/surgery	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	Elbow/hand injury/surgery	_____	_____
Arthritis	_____	_____	Back injury/surgery	_____	_____
Osteoporosis	_____	_____	Knee injury/surgery	_____	_____
Gout	_____	_____	Leg/ankle/foot injury/surgery	_____	_____
Sleeping problems/difficulties	_____	_____	Are you Pregnant?	_____	_____
Emotional/Psychological problems	_____	_____	Do you use Tobacco?	_____	_____

List any other information that would assist us in your care: \_\_\_\_\_

Are you aware of your diagnosis as explained by your doctor?    YES    NO

What are your rehabilitation expectations/goals while in this program? \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Date

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# **SOUTH SHORE** PHYSICAL THERAPY, LLC

## PATIENT DATA SHEET

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_ Work Number #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please circle accident type:

Work Comp                      Auto                      Onset of pain                      Other

Work Comp/Auto Insurance Carrier: \_\_\_\_\_

Work Comp/Auto Insurance Claim #: \_\_\_\_\_

Accident Detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of injury: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_  
(If not an injury, date pain occurred)                      (If applicable)

**THANK YOU!**

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