Holcomb Physical Therapy Plus
3660 Waialae Avenue. Suite 205
Honolulu, HI 96816
Ph: (808) 732-2500
Fax: (808) 732-2501

NEW PATIENT INFORMATION

Patient's Full Legal Name – please provide a copy of your driver's license or other phot identification
Please complete all sections. Thank you.

Last Name:_____First:_____MI:_____

Date of Birth:_____ Age:_____ Sex: M____F___

Address:_____
Street City State Zip

Home phone: ( )_____ Work Ph: ( )_____

Cell Ph: ( )_____ E-mail:_____
*** Place a * on the preferred contact reference you would like for appointment reminders***

Patient status: (check one) Single: ____ Married:_____ Other:_____
Employment Status: (check one) Employed:_____ Retired:_____ Full-time student_____

Employer's Name and Address:_____

Referring Physician:_____ ph:_____

Physician's address:_____

Reason for seeking Physical Therapy (Diagnosis)_____

PRIMARY INSURANCE INFORMATION

Primary insurance company:_____Policy number:_____
Please provide a copy of your insurance card…

Name of Covered Employee:_____

Employer Providing Primary Insurance:_____

Employer Address:_____
Street City, State Zip

Relationship to patient: Self_____ Spouse_____ Parent_____

Insured's name:_____ Insured's date of birth:_____

Secondary insurance name:_____

Secondary insurance policy number_____

Office use only- dx code(s)_____

MEDICAL HISTORY

Date of injury_____ Date of surgery_____

Please give a brief description of the condition you are coming to physical therapy about. How did it start? When did it begin?

_____

_____

Is your condition: Getting worse_____ better_____ staying the same_____

Past treatments or test for this condition:_____

What are your goals for therapy?_____

Current medications: (MEDICARE PATIENTS must complete full medication report)

Name of drug/ dosage	Reason for taking it	Name of drug/ dosage	Reason for taking it
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		Continue on back if needed	

Please list all surgeries: _____

Allergies: Latex_____Other:_____

Please check all that apply:

Heart disease		Diabetes		Scoliosis (curve of the spine)	
High blood pressure		Thyroid Condition		Depression	
Pacemaker		Parkinson's/ Alzheimer's		Fractures	
Stroke		Cancer		Fibromyalgia	
Lung disease, asthma		Mental Illness		Sexual transmitted disease	
Chronic coughing		Kidney disease		Irritable bowel syndrome	
TB		Urinary or fecal leakage		Others, please list:	
Osteoporosis		Painful intercourse			
HIV/ AIDS		Sexual abuse			
Osteoarthritis		Rheumatoid Arthritis			

Social History
Do you live: Alone_____ With a spouse_____ With others_____
Number of children living with you: _____ Ages_____
Do you exercise on a regular basis? What type?_____
Amount of stress (circle one):
At home low medium high
At work low medium high
Have you had any falls?_____ If so, how many times and how long ago?_____

We will discuss your history completely during the first visit. Is there any other history you would like to tell me about?

Patient signature:_____Date:_____

Privacy Act: I authorize Holcomb Physical Therapy Plus to release medical or other information necessary to provide my treatment and process the claim. I understand this information will not be shared unnecessarily and that my personal information is protected under the Privacy act which this office abides by.

Patient Initials: _____

Consent to treat: I consent to physical therapy services at Holcomb Physical Therapy Plus. In doing so, I understand that such therapy may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that these procedures will be fully explained before they are provided and that I have the right to refuse or stop any treatment at any time without fear of judgment or other repercussions.

Patient Initials: _____

Attendance policy: Your success in PT is dependent on regular attendance in therapy. Please provide 24 hour notice if you are unable to attend. Failed appointments or those cancelled after 24 hours will be charged a $50 cancellation fee. Repeated failures will result in re-evaluation of your need for therapy. Emergencies or weather cancellations will not be charged the cancellation fee. Active therapy requires visits to be spaced no more than 30 days apart. If you do not attend therapy within 30 days of your last visit, you must obtain another referral from you doctor.

Patient Initials: _____

Billing policy

- I authorize Holcomb Physical Therapy Plus to bill my insurance company directly for the covered portion of charges and I authorize payment of medical benefits directly to Holcomb Physical Therapy Plus.
- I understand that I am ultimately responsible for my physical therapy charges and agree to pay my deductible, co-payment, and any charges not reimbursed by my insurance carrier.
- I agree to pay co-payments at the time of service. Percentage co-pays will be approximated and any difference during the final bill will either be reimbursed or billed.
- I agree to pay all other charges within 30 days of receiving the bill. Balance remaining 6 months after initial statement may be subject to 18% interest.
- I understand that some insurance companies require preauthorization, or may have reimbursement limits on physical therapy. I understand that I am responsible for knowing and meeting these requirements.
  ____I have already checked my insurance coverage benefits.
  ____I will check my insurance benefits myself.

  I look forward to working with you, as a partner, to achieve your personal health goals. Please feel free to call me at any time with questions or concerns. Call 808-732-2500. An answering machine is on at all times if I am not available. Let me know how I can help you. A copy of this page will be provided at the time of your visit for your future reference.

  Patient Signature:_____ Date:_____