Kona Rehab
PHYSICAL THERAPY

TERMS & CONDITIONS OF OUTPATIENT REGISTRATION

Welcome to Kona Rehab, a division of Crossroads Rehab LLC.

It is important you are aware of the terms and conditions associated with your registration into our outpatient system. The following terms and conditions are designed to protect your personal information and ensure the best medical care:

Consent to Treatment: The undersigned patient registers himself/herself as an outpatient of this facility and voluntarily consents to rehabilitation treatment in all therapy modalities and/or clinic services rendered under the general and special instructions of their referring physician as in their professional judgement may be deemed necessary or beneficial.

Release of Medical Information: I understand that Kona Rehab may use and disclose medical information (as described in the Notice of Privacy Practices) and that I have the related rights described in said Notice. I understand that my clinic record may include personal information, such as phycological services, drug and alcohol abuse and sexually transmitted diseases.

Assignment of Insurance Benefits: In the event the undersigned is entitled to outpatient benefits of any type whatsoever arising out of any policy of insurance insuring patient's bill, and it is agreed that this facility shall discharge the said insurance company of any and all obligations under the policy to the extend of such payment, the undersigned and/or patient being responsible for all charges not paid pursuant to this assignment. All services approved for payment by the Worker's Compensation carrier (for work related injuries) shall be the responsibility of the patient's employer and the patient shall not be held responsible for all such work-related treatments.

Financial Agreement: The undersigned agrees, whether they as an agent or as a patient, that in considerations of services to be rendered to the patient, he/she hereby individually obligates him/herself to pay the account of the outpatient services in accordance with the regular rates and terms of the outpatient service. Should the account be referred to an attorney for collection, the undersigned agrees to pay reasonable attorney's fees and collection expenses.

FOR MEDICARE PATIENTS ONLY: Medicare hospital and medical insurance benefit social security act-patient certification, authorization to release information and payment: I certify that the information given by e in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the above named patient to release to the Social Security administration or its intermediaries any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf to the facility.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, HAS BEEN OFFERED A COPY THEREOF, AND IS THE PATIENT, OR DULY AUTHORIZED BY THE PATIENT AS THE PATEINT'S GENERAL AGENT TO EXECUTE THE ABOVE, AND ACCEPTS ITS TERMS.

This is a total and complete agreement. Any changes and/or deletions made herein to this contract can only be valid with the expressed written consent of both parties.

__________ ____ _________________________________

Date Signature of Patient, Agent, or Representative Witness

__________ I acknowledge receipt of Kona Rehab's Notice of Privacy Practices.

Initial

OFFICE USE ONLY: Acknowledgement of receipt of Notice of Privacy Practices was NOT obtained because:

Reason:____ Employee Initials/Date:____________________

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PHYSICAL THERAPY

75-1029 Henry Street, Suite 101
Kailua-Kona, HI 96740
Ph: (808) 334-0806 / Fax: (808) 334-0483

Kona Rehab – Patient Registration

PATIENT CONTACT INFORMATION

Last Name:__________ First Name:__________ Middle Initial:__________

Address:__________ City:__________ State:__________ Zip Code:__________

Cell #:__________ Home #:__________ Work #:__________

Email:__________

Date of Birth:__________ Gender:__________ Marital Status:__________

EMERGENCY CONTACT INFORMATION

Last Name:__________ Relationship:__________

First Name:__________ Phone #:__________

EMPLOYER INFORMATION

Company Name:__________ Phone #:__________

Address:__________ City:__________ State:__________ Zip Code:__________

REFERRAL DIAGNOSIS

Date of Injury/Onset:__________ Work Related Injury: Y / N ?__________ Auto Injury: Y / N ?__________

Referring MD:__________

Primary Care Physician (PCP):__________

PRIMARY INSURANCE

Insurance:__________ ID#:__________ Member #:__________

Subscriber:__________ Date of Birth:__________ Relationship:__________

Deductible:__________ Copay / Co-Insurance:__________ Max Benefit:__________

SECONDARY INSURANCE

Insurance:__________ ID#:__________ Member #:__________

Subscriber:__________ Date of Birth:__________ Relationship:__________

Deductible:__________ Copay / Co-Insurance:__________ Max Benefit:__________

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the Terms and Condisitons as outlined on the Patient Registration Form.
I hereby acknowledge the copy of the NOTICE OF PRIVACY PRACTICES was made available to me.
[You have the right to refuse to sign this acknowledgement if you so choose]

Patient Signature:__________ Date:__________

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Cancellation, No Show and Discharge Policy

To our valued patient:
RE: Cancellation, No Show, Tardiness and Discharge Policy

To provide you with the best possible care, we ask that you attend ALL of your scheduled appointments. Please arrive on time for your appointment. In the event that you are late, please be mindful of our schedule and notify us at (808) 334-0806.

NOTE: Depending on how late you might be, we may need to reschedule your appointment for another time or day.

If you are unable to make your appointment, please provide us with 24 hours advance notice, otherwise you will be charged a $50.00 fee. **Please, be aware that your insurance will *NOT* cover this charge.**

You will be discharged from therapy, and your referring doctor will be notified under the following circumstances:

1. After two (2) ***no shows***, the rest of your schedule will be cancelled. If you wish to schedule an appointment, please call (808) 334-0806; otherwise you will be discharged.
2. You have met your goals – or –
3. Appropriate services do not improve your condition after a reasonable time frame.

If you have any questions, please contact us at (808) 334-0806.

I understand the above Cancellation/No Show/Discharge Policy and have been provided the opportunity to have my questions answered.

Patient Signature:______________________________________Date:____________