HANA LIMA PHYSICAL THERAPY

PH: 808-446-0382
FAX: 808-876-0245
HANALIMAPT@GMAIL.COM
59 AKEA PL, KULA HI 96790

Patient Name: _____

Birthdate: _____ Age: _____ Gender: M F

Mother's Name: _____ Father's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Other Phone: _____

Primary Care Physician / Clinic: _____

Diagnosis (if known): _____

Insurance: _____ Policy #: _____

Policy Holder & Date of Birth: _____

Consent for Treatment & Privacy Statement

I, the undersigned, do hereby agree and give consent for HANA LIMA PHYSICAL THERAPY LLC to provide medical treatment considered medically necessary in diagnosing my medical condition. Additionally, I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to HANA LIMA PHYSICAL THERAPY LLC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment. I understand that I am responsible for the balance due in full in the event that my insurance carrier denies payment

I understand that my rights to privacy are set forth and explained in The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that, if I had any questions, they were answered to my satisfaction. I hereby authorize HANA LIMA PHYSICAL THERAPY LLC to release all information necessary, including medical records, to my Primary Care Physician, Primary Care Clinic, and / or relevant specialists, to facilitate my medically necessary Plan of Care and overall continuity of care.

_____ _____
Printed Name Signature

_____ _____
Parental Signature, if applicable Date