



PH: 808-446-0382
 FAX: 833-520-1530
 HANALIMAPT@GMAIL.COM
 HANALIMAPT.COM

Name: _____ Birthdate: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Primary Care Physician: _____

Check One:

Primary Insurance: _____ Policy Holder / DOB: _____

Policy #: _____ PPO HMO

No Fault MVA / Worker's Compensation:

Claim #: _____

Company: _____ Date of Injury: _____

Adjuster: _____ Phone #: _____

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