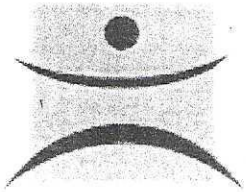

PATIENT REGISTRATION

Welcome! Thank you for allowing Yoshimoto Physical Therapy to be your physical therapy provider. We greatly appreciate you and your physician's trust in us. We will make every effort to ensure that your experience is positive and effective.

100% attendance is vital for optimal improvement and achieving your rehabilitative goals. Please attend all scheduled appointments.

Name: (Last):_____ (First):_____ (M.I.):_____Date of Birth:_____
Soc. Sec: _____ - _____- _____ Home: _____ Work:_____ Cell: _____
Address: _____
City State Zip Code
Occupation: _____ Employer: _____
Address: _____
City State Zip Code
Email:_____
I learned about Yoshimoto Physical Therapy from:
∇ My Physician ∇Commercial ∇ Nurse Case Mgr/Adjustor ∇ Other: _____
∇ A Friend/Relative (Please write their name, if a former patient): _____

EMERGENCY CONTACT (Nearest Relative, preferably not living with you):
(Name): _____ (Relationship): _____ (Phone): _____

PATIENT MEDICAL HISTORY

Please tell us about your current condition:
Symptoms that brought you to physical therapy: _____
_____
Date Symptoms Started: _____ Where?: ∇ Home ∇ Work ∇ Auto ∇ Other: _____

What "relieves" your symptoms?: _____
What "aggravates" your symptoms?: _____
When are your symptoms the best and worst?: Best: _____ Worst: _____
Have you taken Cortizone?: ∇ No ∇ Yes

Did you have prior physical therapy? ∇ No ∇ Yes If so, what was your injury, when was it treated, and how many treatments did you receive? _____

Previous Surgeries (Dates): _____
Current Medication: _____
Have you ever been hospitalized for this condition? ∇ No ∇ Yes, how long: _____
When is your next MD appointment? _____

Do you currently have the following?

∇ Asthma ∇ Epilepsy ∇ Hypertension ∇ Psoriasis
∇ Cancer ∇ High Cholesterol ∇ Osteoarthritis ∇ Rheumatoid Arthritis
∇ Diabetes ∇ HIV/AIDS ∇ Osteoporosis ∇ Stroke

Eyes

∇ pain ∇ redness ∇ loss of vision ∇ double/blurred vision

Ears-Nose-Mouth-Throat

∇ ringing in ears ∇ loss of hearing

Cardiovascular

∇ irregular heartbeat ∇ sudden changes in heart beat ∇ heart murmur ∇ Other: _____
∇ shortness of breath during normal daily activities ∇ chest, shoulder or jaw pain last 6 months

Musculoskeletal:

∇ morning stiffness, lasting how long? _____ minutes _____ hours
∇ joint pain ∇ muscle weakness ∇ muscle tenderness
∇ joint swelling: list joints affected in the last 6 months: _____

Neurological:

∇ headaches ∇ fainting ∇ night sweat ∇ loss of consciousness
∇ dizziness ∇ muscle spasms ∇ memory loss ∇ sensitivity/pain in hand or feet

Integrumentary (Skin and Breast):

∇ easy bruising ∇ redness ∇ rash ∇ color changes or pain in hands or feet in cold

Psychiatric:

∇ anxiety ∇ depression ∇ difficulty falling asleep ∇ difficulty staying asleep

Endocrine:

∇ excessive thirst

Gastrointestinal:

∇ bowel or bladder irregularities ∇ abdominal pain or problems

Miscellaneous:

∇ weight loss or gain greater than 10-pounds without dieting or change in exercise habits

Are there any other concerns that have not been addressed in the questionnaire? If so, please explain:

_____
_____
_____

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CONSENT FOR TREATMENT & PATIENT FINANCIAL RESPONSIBILITY

Yoshimoto Physical Therapy, LLC, (YPT) appreciates the confidence you have shown in choosing us to provide for your health care needs.

I hereby agree to give my consent to YPT to furnish medical care and treatment considered necessary and proper in treating my physician diagnosed physical condition. The services I have elected to participate in, implies a financial responsibility on my part. The responsibility obligates me to ensure payment in full of YPT fees.

I agree to assign to Yoshimoto Physical Therapy, LLC all proceeds from my insurance company or other third-party payers until my outstanding balance is paid in full. I hereby assign my insurance benefits to be paid directly to Yoshimoto Physical Therapy, LLC, and authorize YPT to furnish medical information to insurance carriers concerning my care to process my claims. I am ultimately responsible to know my coverage and benefits, and responsible for any amounts not covered by my insurance. I understand that if my insurance carrier or the State Department of Labor and Industrial Relations rejects or reduces any portion of my claims, or if I elect to continue services past my coverage policy period, it does not relieve me from my financial obligation to YPT. All services are subject to Hawaii Excise Tax of 4.712% and a fee of $25 will be charged for returned checks. I am responsible for payment of any deductible and co-payment/co-insurance as determined by my contract with my insurance carrier(s). Payment of all co-payments is expected at the time of service. **Initial:**_____
Should the need arise, I will be responsible for all collection fees, court costs, attorney fees, and other charges incurred in the collection of any balance due. I understand that a fee of as much as 35%, will be added to my total amount balance in accordance with YPT's contract with its Collection Agency.

Cancellation / No Show Policy:
We understand that there may be times when you miss an appointment due to emergencies or obligations to work or family. However, you must call the office **24 hours prior to your appointment time** to cancel or reschedule your appointment. I understand if I miss an appointment without cancelling in advance, I will be charged a no-show fee of $40, and risk being discharged from YPT. **Initial:** _____

I have read the above policy regarding my financial responsibility to YPT, for providing medical services to me or the underaged patient.

_____ _____
Signature: (Patient or Parent/Legal Guardian if under the age of 18) Date

_____
Print Name

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Acknowledgement of HIPAA Privacy & Release of Information Authorization

I hereby authorize Yoshimoto Physical Therapy, LLC, (YPT) and its affiliates, employees and agents, to use my protected health information (e.g. information relating to the diagnosis, treatment, claims payment and health care services) which identifies my name, address, social security number, member ID number for the purpose of medical issues to resolve claims and health benefit coverage issues. I understand that a copy of this agreement will be made available to me upon my request. $0.50 per page plus postage if I wish copies to be mailed to me.

I understand that any personal health information or other information released to the person or organization (e.g. disaster relief, medical examiner, coroner, specialized government functions, court order, public health activities, health oversight activities authorized by law, law enforcement), may be used for re-disclosure of my information and may not be protected under Federal and State laws. I understand that I have a right to revoke this authorization by providing written notice. However, this authorization may not be applied to actions taken matters prior to receiving my written notice. I give this authorization voluntarily and will end upon the completion of the billing and collection process for services rendered. I consent you received contact via phone, email, voicemail for future events and appointments.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may be protected by Federal and State laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign this authorization may affect my eligibility for benefits, enrollment, and payment for, or coverage of services.

I have been advised of YPT's Privacy Practices, Release of Billing Information Policy, and Assignment of Benefits. If applicable, Legal Representatives of a minor under the age of 18, sign below. By signing this form, I represent that I am the legal representative of the minor. I am legally authorized to act on the Member's behalf with respect to this form. I have read and understand the HIPAA/Privacy Policy for Yoshimoto Physical Therapy, LLC

_____ _____

Signature (Patient or Parent/Legal Guardian if under the age of 18) Date

_____

Print