COPTS
Central Oahu Physical Therapy Specialists

Medical History Form

Patient Name: _____ DOB: _____
Mailing Address: _____
Home Number: _____ Cell Number: _____
Referring Physician: _____ Date of Injury: _____
Any Physical Therapy This Year: _____ (how many visits?)
Primary Insurance: _____ Secondary: _____ Tertiary: _____
Height: _____ Weight: _____ Email Address: _____

Are you allergic to any of the following?	**YES**	**NO**	**History of:**	**YES**	**NO**
Heat?			Pregnancy?		
Cold?			Metal implants?		
Latex?			Pacemaker?		
Other:			Previous surgery?		
Do you have a history of any of the following?			Bowel or bladder abnormalities?		
Cancer?			Nausea?		
Respiratory Diseases?			High blood pressure?		
Dizziness?			Previous physical therapy?		
Heart Attack/Heart disease?			Headaches?		
Diabetes?			Stroke?		
Smoking?					

If you answered yes to any of the above questions, please explain below:

_____

_____

_____

Current medications you are taking: **(name, dosage, frequency, route of administration)**:

_____

_____

_____

I hereby authorize Central Oahu Physical Therapy Specialists, LLC to furnish the insurance company with full information regarding treatment rendered, when so requested.

Patient signature: _____ Date: _____
Parent signature (if a minor): _____ Date:_____

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Consent to Use and Disclosure of Protected Health Information

Your protected health information will be used by Central Oahu Physical Therapy Specialists LLC or disclosed to others for the purpose of obtaining payment, treatment, or any healthcare operations of this practice. Central Oahu Physical Therapy Specialists may request copies of your health information from doctors, clinic, insurance agency for purposes above. The information may contain past, present, or future health or insurance information.

You may request a change on the use or disclosure of your protected health information. Central Oahu Physical Therapy Specialists may or may not agree to restrict the use or disclosure of your protected health information. If Central Oahu Physical Therapy Specialists agrees to your request, the change/restriction will be binding on the practice. Any use or disclosure of protected health information in violation of agreed upon restriction is a violation of the federal privacy standards.

Revocation: You may revoke this consent in the use and disclosure of your protected health information. You must revoke in writing to Central Oahu Physical Therapy Specialists LLC. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Central Oahu Physical Therapy may reserve the right to modify the privacy practices outlined in the notice. At which time you will be notified.

I have reviewed this consent form and give Central Oahu Physical Therapy Specialists LLC the right to disclose my health information in accordance with it.

_____ _____

Patient Name Print Patient Signature

_____

Date

_____ _____

Patient Representative Name (print) and relation Signature of Patient Representative

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Medical and Insurance Reimbursement Release Form

Insured of Authorized Person's Signature: I authorize the release of medical or any information necessary to management of claims provided by Central Oahu PT Specialists LLC. I authorize that all payment of medical benefits directly to Central Oahu PT Specialists LLC that includes all private and government benefits. I am financially responsible for all non-covered charges- ie deductible, co-payment, non-covered third party claims (worker's compensation, no fault)

Workers' Compensation Cases: Charges for services incurred as a result of a verified work-related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation, you will be required to pay all amounts due within thirty (30) days.

Signature: _____

Date: _____

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Cancellation / No Show Policy

If you need to cancel a scheduled appointment, please give us at least a **24-hour notice** prior to your appointment (except for unforeseen emergency situations).

If you no show to **(1)** scheduled appointment or do not give adequate notice (**24 hrs**) to cancel, we will require a confirmation call or voicemail stating you will be in attendance of your next scheduled appointment. **If no confirmation is received by 12PM the day prior to your next scheduled appointment, the appointment will be cancelled and no longer valid.**

If you no show to **(2)** scheduled appointments or do not give us adequate notice (**24 hrs**) to cancel, **you will be discharged or discontinued from our physical therapy services, and a new referral will be needed to reschedule.**

Signature: _____

Date: _____

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Liability Waiver Form

I have volunteered to participate in a Physical Therapy Program issued by Central Oahu Physical Therapy Specialists and its employees, independent contractors and/or any future employees or independent contractors to receive said services. I fully understand and acknowledge the activities in which I will engage as part of physical therapy treatment.

The treatment may include, but is not limited to, one or more of the following: evaluation, manual therapy, joint mobilization and manipulation, soft tissue mobilization, therapeutic exercise, neuromuscular re-education, therapeutic activities, and modalities including, but not limited to, ultrasound, electrical stimulation, use of various exercise equipment. I acknowledge there are inherent risks involved in any evaluation and treatment program. My participation in physical therapy treatments may result in possible injury or illness including, but not limited to, bodily injury, disease, strains, stiffness, paresthesias, paralysis, fractures, including the rare and unlikely risk of death.

The possible benefits of this treatment include, but are not limited to one or more of the following: improved cardiovascular fitness, muscle strength, endurance, flexibility, body posture, smoother movement, alignment, and decreased pain, dizziness, numbness and tingling. I hereby assume all of the foregoing risks and dangers and personal responsibility for any losses, other damages or other injury I might suffer. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Central Oahu Physical Therapy Specialists, their employees, representatives, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I am satisfied with my understanding of the more common risks and complications of the evaluation and treatment.

I consent to and authorize Central Oahu Physical Therapy Specialists to administer physical therapy treatment under the direction and supervision of the licensed physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

I have the right to choose what treatment I do or do not receive in addition to withdrawing from any treatment at any time. I understand that a physician's examination and approval was obtained prior to participation in a health care program.

I recognize that my participation in the activity covered hereby is conditioned upon my signing and returning this waiver and release. I understand that I may show this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY to, and consult with, my own independent legal counsel before signing.

I have read and understood this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY and it accurately sets forth my intentions and I agree to be bound by its provisions.

Print Name: _____ Date: _____

Signature: _____

If Under 18 Years of Age:

Parent or Legal Guardian Name and Signature: _____

Central Oahu Physical Therapy Specialists

COVID-19 Waiver and Release of Liability

In consideration of the risk of contracting COVID-19 virus while participating in live in person physical therapy, and as consideration for the right to participate in physical therapy treatments, I hereby, for myself, my heirs, executors, administrators, or personal representatives, knowingly and voluntarily enter into this waiver and release liability and herby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in physical therapy , and do hereby release Central Oahu Physical Therapy Specialists, LLC, their affiliates, managers, employees, members, agents, staff, attorneys, volunteers, heirs, representatives, predecessors, successors and assigns for any physical or psychological injury, including but not limited to illness, death, damages, economical or emotional loss associated with possible exposure to COVID-19 that I may suffer as a direct result of my participation in physical therapy sessions, including traveling to and from the clinic.

I am voluntarily participating in physical therapy and acknowledge social distancing practices may not be possible due to necessary direct patient contact with physical therapist, as well as incidental contact that may occur with other staff and patients in the clinic. I am participating entirely at my own risk and am aware of risks associated with live in person physical therapy treatments during the time of the Covid-19 Pandemic. I am aware of the risks for traveling to and from the clinic, as well as treatment within the clinic may inadvertently expose me to COVID 19 without my knowledge, causing illness and possible death associated with the virus. I am satisfied with my understanding of the risks and complications that may occur during live in person physical therapy treatments during the Covid-19 Pandemic.

I consent to and authorize Central Oahu Physical Therapy Specialists to administer physical therapy treatments that may not include recommended social distancing practices during the Covid-19 pandemic.

I have the right to choose what treatment I do or do not receive in addition to withdrawing from any treatment at any time.

I agree to have a forehead temperature scan at the start of each session, and will not participate if I have a temperature above 99.5˚F. I agree to wear a facial mask covering my mouth and nose at all times while in the clinic.

I have answered "No" to all COVID-19 screening questions, including but not limited to. If yes I will need MD note to cont. PT:

1) Travel off island within 5 days or contact with anyone who traveled
2) Contact with someone who tested positive for Covid-19 virus or quarantining due to direct exposure or myself.
3) Have the following symptoms or contact with anyone who has the following symptoms: cough, shortness of breath, temperature above 99.5 ˚F, chills, body aches, headaches or recent gastrointestinal abnormalities runny nose.
4) If yes to lines 2→ 4 need MD note to return back to PT

I recognize that my participation in physical therapy is conditioned upon my signing and returning this liability waiver and release. I understand I may show this waiver and release to, and consult with, my own independent legal counsel before signing.

I have read and understood this waiver and release of liability and it accurately sets forth my intentions and I agree to be bound by its provisions.

Print Name: _____ Date: _____

Signature: _____

If under 18 years of age: Parent or Legal Guardian Name and Signature: _____