Aloha! Mahalo for allowing Na'au Pono Physical Therapy to serve as your provider for physical therapy care. We appreciate the trust you and your physician have placed in us. If you have any questions or need any assistance please feel free to ask! Mahalo nui!

NA'AU PONO

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION TO INSURANCE COMPANY

I hereby authorize Na'au Pono Physical Therapy, LLC or its representative, Team Praxis, LLC, to release to my insurance company or its representative my information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, Tricare, Private Ins., and any other health plan to Na'au Pono Physical Therapy, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with collection costs (plus $20.00 processing fee) and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize said assignee to release all information necessary to secure payment.

Signature _____ **Date** _____

PATIENT ATTENDANCE

A consistent treatment schedule is vital to the success in your physical therapy progress. Not adhering to the schedule set by you and your therapist could hinder the achievement of desired outcomes.

At Na'au Pono Physical Therapy, we strive to provide you with the highest quality of care while attempting to accommodate your schedule. Cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. Therefore, we must ask for your full cooperation with the following policy:

- If you are unable to keep your appointment, **we request that you notify our office 24 hours in advance of your scheduled appointment time.** If someone is not available to take your call, please leave a message on our answering system.
- If you no-show for two (2) consecutive appointments, **we may charge you a no-show fee of $120.00 or cancel any future scheduled appointments**, you may be referred back to your physician, or your therapist may discharge you from their care.
- All cancellations and no-shows will be documented in our medical records, and in certain situations, such as workers' compensation cases, we are required to report treatment compliance to your adjuster/case manager.

We recommend that you make up a missed appointment within the same week in order to comply with your established treatment plan.

I have read, understand, and agree to the Patient Attendance Policy. *(Please initial)* _____

COST OF TREATMENT

The cost of your treatment may be covered in whole or in part by your insurance company. **You are responsible for payment of any deductibles, copays, or denied claims.** Paying deductibles or copays on the same day of your visit will minimize your after-visit costs following our monthly billing cycles and is highly recommended. **Failure to take action on balances aged more than 90 days will result in your account being sent to collections.** Please contact your insurance company directly for your individual physical therapy benefits.

Cash, check, or credit card may be used for payment. There is a $25.00 fee for returned checks.

I have read, understand, and agree to the Cost of Treatment Policy. *(Please initial)* _____

CONSENT TO DISCLOSE HEALTH INFORMATION & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please read our Notice of Privacy Practices as it provides a description of our treatment, payment activities, and healthcare operations and outlines the use and limitations of the disclosure of your health information and your rights as a patient. We reserve the right to change our privacy practices in accordance with the law. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

I have been given a copy of Na`au Pono Physical Therapy, LLC's Notice of Privacy Practices. *(Please initial)* _____

I authorize Na'au Pono Physical Therapy, LLC to use and disclose my (or my child's) health and medical information for the purpose of Treatment, Payment, and Healthcare Operations.

I understand that I have the right to revoke this consent provided that I do so **in writing**, except to the extent that Na'au Pono Physical Therapy, LLC has already used or disclosed the information reliance on this consent.

YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.

(Revised July 2022)