MAKAI MOBILE REHAB

Getting Started

1. Print out packet.
2. Take **prescription form** to your doctor and tell why you want physical therapy.
3. If your doctor gives you the form, please make sure to call us for an appointment
   (808) 783-9320.
   If your doctor faxes us the form, once we receive it we will call within 1-2 days to schedule an appointment.
4. Fill out the **patient registration form**.
5. Have your picture ID and insurance cards ready for us to copy on the day of our first visit.

*If you have any questions please call us (808) 783-9320
or email us jason@makaimobile.com

MAKAI MOBILE REHAB

Jason Dacumos PT, MPT, OCS
7114 Niumalu Loop Honolulu, HI 96825
Phone (808) 783-9320 Fax (808) 396-5581

Physical Therapy Prescription

Name:_____ **DOB:**_____

Patient Phone Number:_____**DOS:**_____

Diagnosis / ICD-9 :_____

Primary Insurance:_____ **Secondary:**_____

☐ **Evaluate and Treat**

Services:

- ☐ **Therapuetic Exercise**
- ☐ **Balance**
- ☐ **Gait Training**
- ☐ **AROM / PROM**
- ☐ **other**_____
- ☐ **Soft Tissue Massage**
- ☐ **Jt. Mobilization**
- ☐ **Manual Traction**
- ☐ **Electric Stimulation**

Frequency: _____ **x week /** _____ **weeks**

Special Instructions/Precautions/Treatment Goals:_____

_____

_____

I do hereby certify that it is a medical necessity this patient receives rehabilitation services as an **in-home outpatient physical therapy patient**.

Physician Signature:_____ **Date:**_____

Please fax prescription to (808) 396-5581

Thank You for this referral!

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Patient Registration

7114 Niumalu Loop Honolulu, HI 96825
Phone (808) 783-9320 Fax (808) 396-5581

Name:

_____

(Last) (First) (M.I.)

Date of Birth: ___/____/_____ Male / Female

Doctor:_____

Patient Address:

_____

(Street) (Apt #)

_____

(City) (State) (Zip Code)

Social Security:_____
Home Phone:_____
Cell Phone:_____

Occupation:_____
Employer:_____

Emergency Contact Information

Name:_____
Relationship:_____
Address:_____

_____

Home Phone:_____
Cell Phone:_____
Work Phone:_____

Billing Information

(same as above)

Name on the account:

_____
Relationship:_____
Address:_____

_____

Home Phone:_____
Cell Phone:_____
Work Phone:_____

Insurance Information

Primary Medical Insurance Company:

_____
Subcriber Name:_____
Policy #:_____
Coverage code:_____
Subscriber's Date of Birth:___/___/_____
Secondary Medical Insurance Company:

_____

Assignment of Benefits

I hereby authorize assignment of my medical insurance benefits and/or my Medicare benefits to Makai Mobile Rehab, LLC for application to the bill for services furnished to me by that practitioner. I further authorize Makai Mobile Rehab, LLC to receive direct payment of all such benefit payments. I agree to remain responsible and liable for payments of all amounts due to Makai Mobile Rehab, LLC and not received from my insurance carrier(s). I SHALL NOT REVOKE THIS ASSIGNMENT FOR ANY REASON.

Signed:_____**Date:**_____

I hereby authorize the release of medical information requested for completion of medical claim form of the above mentioned insurance companies covering services rendered to the patient.

Signed:_____**Date:**_____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment , or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care options, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this documents, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice.

Print name: _____ Signature: _____

Today's date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very nighest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.