HHRS PATIENT INTAKE FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME		MIDDLE NAME
STREET ADDRESS		CITY	STATE / ZIP CODE
EMAIL	DATE OF INJURY	DATE OF SURGERY	PRIMARY CARE PHYSICIAN (PCP)
HOME PHONE	WORK PHONE	CELL PHONE	REFERRING PHYSICIAN
BIRTHDATE	GENDER ☐ Male ☐ Female	EMERGENCY CONTACT	ALT. CONTACT'S # / RELATIONSHIP
SOCIAL SECURITY #	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
EMPLOYER	EMPLOYER PHONE	SPOUSE (NAME)	SPOUSE (BIRTHDATE)

IF PATIENT IS A CHILD, PLEASE COMPLETE THIS SECTION

PARENT/GUARDIAN NAME	RELATIONSHIP TO CHILD	Home: Cell: Business:
CHILD'S SCHOOL	PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR MY CHILD	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		POLICY OR ID # / CLAIM #
SUBSCRIBER'S NAME	BIRTHDATE	RELATIONSHIP TO PATIENT
SOCIAL SECURITY #	EMPLOYER	EFF. DATE OF INSURANCE
SECONDARY INSURANCE COMPANY		POLICY OR ID # / CLAIM #
SUBSCRIBER'S NAME	BIRTHDATE	RELATIONSHIP TO PATIENT
SOCIAL SECURITY #	EMPLOYER	EFF. DATE OF INSURANCE

WORKERS COMPENSATION / AUTO ACCIDENT CLAIM

INSURANCE NAME	CLAIM NUMBER
ADJUSTER NAME	ADJUSTER PHONE
ATTORNEY NAME / PHONE	ADJUSTER FAX

CURRENT SYMPTOMS

Have you received previous treatment for current symptoms? ☐ Yes ☐ No		Date Last Treated
Name of facility where previous treatment received	Date of surgery	Next physician visit

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION: I agree to have insurance payments sent directly to Hawaii Hand & Rehabilitation Services LLC for services rendered. I agree to have Hawaii Hand & Rehabilitation Services release medical information to my insurance company.

FINANCIAL AGREEMENT: I understand that I am financially responsible for allowable charges not paid by insurance. These include deductible, co-payment, cost-share and/or non-covered benefits. I promise to pay Hawaii Hand & Rehabilitation Services LLC in full for any outstanding balance in the event insurance fails to authorize or reimburse Hawaii Hand & Rehabilitation Services LLC for services rendered. I agree to pay a late payment fee of 1% a month on any unpaid balance over 90 days old and any reasonable attorney fees should my account be referred to an attorney or collection agency. I agree to pay $25 for each returned check. I understand that if I do not give a 24-hour notice of cancellation, I will be charged a $20 cancellation/no-show fee that is not billable to insurance. I understand that verification of benefits does not guarantee payment.

I certify that the information stated herein is correct and permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

I have read and accept the terms and conditions of the HHRS NOTICE OF PRIVACY and have been offered a copy.

_____ _____

Patient / Parent / Guardian Signature Date