



INTEGRATIVE HEALTHCARE GROUP & REHABILITATION CENTER

Please provide the following information completely, to the best of your ability, so that we can provide you with the best service possible in all aspects of your treatment at our facility. Thank you.

PERSONAL INFORMATION

Last Name _____ M.I. _____ First Name _____

Address _____ City _____ State _____ Zip Code _____

Home # _____ Work # _____ Cell # _____

Gender Male Female Date of Birth _____ Marital Status: _____ SS # _____

Occupation _____ Employer _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

INSURANCE INFORMATION

Primary Ins. _____ Secondary Ins. _____

Insured Name: _____ Insured Name: _____

Relationship: _____ D.O.B: _____ Relationship: _____ D.O.B: _____

Subscriber # _____ Subscriber # _____

Referred By: _____ Primary Dr.: _____

W/C Injury NF Injury TPL Injury Insurance _____

Date of Injury _____ Claim # _____

Adjuster _____ Phone # _____ Ext. _____

Attorney Name _____ Phone # _____

I understand and agree that health and accident insurance policies are in agreement between an insurance carrier and myself. I authorize payment from my insurance carrier to be sent directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that monies rendered to me are charged directly to me and that I am personally responsible for payment. Furthermore, if my insurance carrier denies payment of my services, or I exceed maximum allowable benefits, I agree to pay all outstanding bills. I also understand that if I suspend or terminate my care that fees for professional services rendered to me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with any collection cost and reasonable attorney fees as may be required to effect collection.

There will be a \$25 processing fee for all returned checks.

Signature _____ Date _____



INTEGRATIVE HEALTHCARE GROUP & REHABILITATION CENTER

Dear Patient,

We would like to thank you for your confidence in and support of our clinic, and the emerging field of integrative healthcare. It is your support and commitment that has allowed us to flourish and to provide you and our community with the highest quality integrative healthcare. We hope that Manakai 'O Malama will continue to be your partner in health for years to come.

We are always looking at ways to improve our performance and we welcome your feedback as a way to direct our efforts.

We would like to take this opportunity to review our cancellation policy. Your visits are a crucial part of your treatment plan and recovery process. Your individual treatment plan is also designed for your maximum benefit. By missing an appointment or by arriving late and reducing your treatment time you may interrupt the healing process. We do understand that the unexpected happens, and that injury or illness may cause forgetfulness, 'bad days,' etc. To come in for treatment may be the best antidote for those 'bad days'. We ask for your consideration of the following simple guidelines:

Late Arrival - Please call if you expect to arrive more than 10 minutes late for an appointment. Our practitioners will do their best to accommodate you if they can do so without disrupting another patients' care. If you are more than 15 minutes late your appointment may be rescheduled and you may be charged a missed appointment fee. **Initial** _____

Appointment Cancellations - If you need to cancel an appointment, please give us 48 hours' notice. This allows us to reassign that time slot and reschedule your treatment as needed. Appointments rescheduled within 48 hours may be subject to a **reschedule fee of \$25**. **Initial** _____

Missed Appointments - If you miss 3 appointments without cause or notification we do reserve the right to suspend your treatment. If you do not show up for a scheduled appointment you may be charged a **\$50 missed appointment fee** for the visit. **Initial** _____

By abiding by these guidelines you can help us maximize our efficiency and your service delivery. On our part, we will continue to make every effort to stay on schedule, to ensure wait times are short, and to offer you the highest quality healthcare.

Mahalo from all of us at Manakai 'O Malama.

I have read the above and agree to make every effort to abide by these guidelines in the future.

Patient Name: _____

Patient signature: _____ Date: _____



HAWAII PRIVACY OF HEALTH CARE INFORMATION LAW
INTEGRATIVE HEALTHCARE GROUP & REHABILITATION CENTER

In accordance with the American Medical Association Code of Ethics, we believe that the patient-physician relationship is based on trust and confidentiality of communication. The free and uninhibited disclosures of personal information within this relationship are the cornerstone of good medical care.

The privacy of your medical records is of the utmost importance to our staff and us. We have therefore taken measures to ensure that your medical records receive the highest level of confidentiality and security. This office adheres to the following procedures to ensure protection of your private medical records.

- Our office staff has received education and training regarding the use and handling of patients protected health information.
- Your records are secured in this office.
- Access to office keys is limited to our doctors, staff, and bonded cleaning crew.
- Access to electronic information is only released as required or permitted by state or federal law.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____, hereby authorize Manakai O Malama Integrative
(Patient, parent or legal guardian)

Healthcare Group to disclose health information, including copies or summaries of medical records for
_____ to:
(Name of patient)

- Any health insurance plan or company that provides insurance coverage for the purpose of payment of charges,
- Any insurance company that provides liability insurance coverage for Ira Zunin, MD, Christopher Acree, PA for the purpose of evaluating the treatment rendered or
- Any health care provider that has referred the patient to this office for care, for the purposes of coordination of medical care.

This authorization shall cover the period of time from my first visit to my last visit. I understand that I can revoke this authorization at any time. This authorization shall end two years after the date of my last visit.

Signature Date

MEDICAL INFORMATION RELEASE

I hereby authorize the staff of Manakai O Malama to release my confidential medical information to the following:

Name _____ Relationship _____ Phone# _____

Signature Date

Occupational Medicine Pre-appointment Questionnaire

Patient Name: _____ **Date of Birth:** _____

Date of Accident: _____

Is this due to (circle one): Auto Accident Work Injury Other: _____

Name of Employer: _____ Phone Number: _____

Human Resources Representative: _____ Phone Number: _____

Longshoreman/Stevedore/Seaman: ___ Yes ___ No

Was a "Report of Industrial Injury" filed with your employer? ___ Yes ___ No ___ N/A

Workers Compensation Carrier: _____ **N/A** _____

Claim #: _____

Adjuster's Name: _____ **Phone Number:** _____

Have you previously been treated for this injury? ___ Yes ___ No

If "Yes" who was the treating provider? _____

Location: _____

Diagnosis: _____

Are you here to establish/transfer care? ___ Yes ___ No

If you are here to transfer care please notify your adjuster

Body Part(s) Injured: _____

Are your symptoms: Improving Getting Worse Staying the Same Come and Goes Activities that aggravate:

Standing Walking Sitting Lying Bending Lifting Twisting Coughing Sleeping

Other: _____

Are you experiencing any of the following?

<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Headache	<input type="checkbox"/> Runny nose
<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Sleep disturbance*	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Malaise/Fatigue*	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Eye Redness
<input type="checkbox"/> Double vision	<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Ear Pain
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Ear Drainage	<input type="checkbox"/> Swallowing pain	<input type="checkbox"/> Chest Pain*
<input type="checkbox"/> Palpitations*	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Swelling/Edema	<input type="checkbox"/> Pain in Limb *
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Breathing discomfort	<input type="checkbox"/> Blood in sputum
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea/ Vomiting	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Bloating	<input type="checkbox"/> Black/Bloody stool	<input type="checkbox"/> Loose stool	<input type="checkbox"/> Constipation
<input type="checkbox"/> Pain w/ urination	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Frequent/Urgent urination
<input type="checkbox"/> Impotence	<input type="checkbox"/> Irregular menses	<input type="checkbox"/> Neck pain/stiffness	<input type="checkbox"/> Back pain
<input type="checkbox"/> Muscle aches	<input type="checkbox"/> Swollen joints	<input type="checkbox"/> Muscle Stiffness	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Bruising	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Rash	<input type="checkbox"/> Boils
<input type="checkbox"/> Lesions/Moles	<input type="checkbox"/> Changing mole(s)	<input type="checkbox"/> Sun Sensitivity	<input type="checkbox"/> Tingling
<input type="checkbox"/> Poor balance	<input type="checkbox"/> Falling	<input type="checkbox"/> Numbness	<input type="checkbox"/> Fainting
<input type="checkbox"/> Heat/cold Intolerance	<input type="checkbox"/> Speech Difficulty	<input type="checkbox"/> Weakness	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fear	<input type="checkbox"/> Loss of Interest	<input type="checkbox"/> Suicidal Thoughts