KAILUA WELLNESS CENTER

CHIROPRACTIC PHYSICAL THERAPY ACUPUNCTURE MASSAGE

KAILUA WELLNESS CENTER
228 Ku'ulei Road
Kailua, HI 96734

Ph: (808) 261-8181
Fax: (808) 261-7770

NO FAULT-WORK COMP FORM

This information is mandatory. We are unable to see you until all information is completed and validated.

PATIENT NAME (LAST, FIRST) | **DATE OF BIRTH** | **TODAY'S DATE**

INSURANCE INFORMATION

NO FAULT INSURANCE

INSURANCE CARRIER COMPANY | **CLAIM NUMBER** | **DEDUCTIBLE AMOUNT**

ADJUSTOR NAME (FIRST AND LAST) | **PHONE NUMBER** | **FAX NUMBER** | **EMAIL ADDRESS**

PRIVATE INSURANCE

INSURANCE COMPANY NAME | **POLICY NUMBER / SUBSCRIBER ID** | **NAME OF SUBSCRIBER**

***Annual Deductible** | ***PIP information** | ***PIP Balance**

*(Ded & PIP information is for the patient and clinic benefit. If PIP and No Fault benefits are exhausted, we will bill the patient's commercial insurance. If the claim is denied or not covered, the full balance becomes the patient's responsibility and is due to Kailua Wellness Center within 30 days of the denial or exhaustion date.)

Is there an attorney involved? [Y / N]

ATTORNEY INFORMATION

ATTORNEY NAME (FIRST AND LAST) | **PHONE NUMBER** | **FAX NUMBER** | **EMAIL ADDRESS**

ACCIDENT/INJURY INFORMATION

_____ _____

DATE OF INJURY **LOCATION OF INJURY (CITY, STATE)**

INJURY INFORMATION:

Acknowledgement of Receipt of Privacy Practices;

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up care among multiple health care providers.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations.

I have been informed by you (KWC) of your privacy practices concealing a more complex description of the uses and disclosure of my health information (available in the office in print form). I have reviewed such notice prior to signing this contract and acknowledge that I have reviewed the privacy practices. I understand that I may contact this office for a copy of the Notice of this Privacy Practices.

Were you taken to the hospital? [Y / N] If yes, which hospital? _____

Were X-Rays and/or MRIs taken? [Y / N]

Did you file a police report? [Y / N] If yes, what is the report number? _____

Have you received treatment at any other office for this injury? [Y / N] If yes, where? _____

Please describe how your injury/accident occurred. Describe any treatment you have already received. (e.g. Emergency Room visit, MRI, X-rays):

_____

_____

_____

_____

Are you currently working? [Full Time / Part Time / Full Disability]

LIEN LETTER

In the event my No Fault or 3rd party liability compensation for this injury/illness is denied for any reason, or it is determined by either the No Fault or 3rd party liability compensation's board that the illness/injury is not a compensable case, **I hereby agree to pay Kailua Wellness Center**, their **usual and customary fees for services rendered** within 30 calendar days of the date(s) of denial(s) of benefits via written notice letter.

_____ _____ _____

Patient Name: Patient signature Date