Craig B. Nagata, PT
Taylor Lau, PT, DPT

ORTHOPEDIC REHABILITATION
SPECIALISTS

1600 Kapiolani Blvd., Suite 600
Honolulu, Hawaii 96814
Phone: (808) 979-0700
FAX: (808) 979-0707

Name: ____
Last First MI

Mailing Address: ______________________ ____________ ________ __________
City State Zip Code

Primary Phone: ____________ Secondary Phone: ____________ Email Address: ____________

May we leave phone messages for you at your primary phone number? Yes No May we contact you by email? Yes No

Birthdate: ______/______/______ Gender: M F Marital Status: S M W D
MM DD YYYY

Employer: ______________________ Occupation: ______________________

Emergency Contact: ____
Name Relationship Phone #

Primary Insurance: ______________________ Member/Subscriber #: ______________________

Subscriber's Name: ______________ Relationship to Subscriber: ________ Subscriber's Birthdate: ____/____/____
MM DD YY

Secondary Insurance: ______________________ Member/Subscriber #: ______________________

Subscriber's Name: ______________ Relationship to Subscriber: ________ Subscriber's Birthdate: ____/____/____
MM DD YY

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION TO INSURANCE COMPANY: I hereby authorize Orthopedic Rehabilitation Specialists or its billing service, TeamPraxis, to release to my insurance company any information including the diagnosis and the records of any treatment or examination rendered to me. I hereby authorize payment of medical benefits to ORS for services rendered.

FINANCIAL AGREEMENT AND PAYMENT POLICY: I understand that it is my responsibility to provide my most current insurance information and to contact my insurance carrier to determine my coverage and the terms to which they apply. I understand that if my insurance carrier denies payment I am responsible for payment in full. Estimated cost per visit is $150.00. I understand that I will be assessed $25.00 for returned checks due to insufficient funds and any outstanding balance over 120 days old will be assessed a monthly late fee of $2.00. In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs 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.

INFORMED CONSENT: I understand that there are certain inherent risks associated with physical therapy and that it often involves some amount of discomfort My therapist will communicate the benefits and potential risks of treatment to me and I can ask questions at any time. I understand that I am the only person who knows my symptoms and it is my responsibility to report any severe discomfort or increase in pain. I agree to participate in physical therapy treatment and comply with my plan of care.

LATE CANCELLATION / NO SHOW POLICY: We kindly ask that you notify our office 24 hours in advance for appointment changes or cancellations. A $50 fee will be charged for no show appointments or appointments cancelled with less than 24 hour notice.

Signature: ______________________ Date: ______________
Patient or Patient's Parent or Legal Guardian

EMAIL MARKETING CONSENT: By signing below I agree to have my email information stored and be used to receive information about ORS' physical therapy programs, tutorial videos and the MoveBetter Newsletter. I understand that I can unsubscribe from this service at any time.

Signature: ______________________ Date: ______________
Patient or Patient's Parent or Legal Guardian