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

ORS
ORTHOPEDIC REHABILITATION
S P E C I A L I S T S

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: _____

Employer's Address: _____
Street City State Zip Code

Emergency Contact: _____
Name Relationship Phone #

Worker's Compensation Insurance Carrier: _____

Address: _____

Adjustor: _____ Claim #: _____ Date of Injury: _____

Nurse Case Manager: _____ Employer at the time of Injury: _____
(if different from employer listed above)

I understand that my doctor has given me a prescription for Orthopedic Rehabilitation Specialists, Inc. to provide physical rehabilitation and/or testing services for myself. I understand that the worker's compensation insurance company (as named above) will be billed on my behalf, for my services. I hereby authorize Orthopedic Rehabilitation Specialists or its representative, TeamPraxis, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care. In the event that my worker's compensation claim is denied, I understand that I am financially responsible for all charges. In the event of default, I (we) 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