MANAKAI O MĀLAMA

932 Ward Avenue, 6th floor, Honolulu, Hawaii 96814 ● Phone (808)535-5555 Fax (808)535-5556

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 _____

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EMERGENCY CONTACT INFORMATION:

Name: _____ Phone #:_____Relationship:_____

Name: _____ Phone #:_____Relationship:_____

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INSURANCE INFORMATION

Primary Ins. _____ Secondary Ins. _____

Insured Name:_____ Insured Name:_____

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

Subscriber # _____ Subscriber #_____

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Referred By:_____ Primary Dr.: _____

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❑ 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_____

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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 '0 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: _____

MANAKAI O MĀLAMA

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 of federal law.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____, hereby authorize Manakai 0 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)

a. Any health insurance plan or company that provides insurance coverage for the purpose of payment of charges,
b. Any insurance company that provides liability insurance coverage for Ira Zunin, MD, Christopher Acree, PA for the purpose of evaluating the treatment rendered or
c. 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

Manakai O Malama Integrative Healthcare Group and Rehabilitation Center
932 Ward Avenue, 6th floor, Honolulu, Hawaii 96814 □ Phone (808)535-5555 Fax (808)535-5556

Pre-appointment Questionnaire

What is the main reason for your appointment today?

Is this due to (circle one): ☐ Auto Accident ☐ Work Injury ☐ Other Cause ☐ Unknown ☐ Illness

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same ☐ Come and Goes

Activities that aggravate: ☐ Standing ☐ Walking ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting ☐ Coughing ☐_____

Have you seen another health care provider for this problem? ☐ No ☐ Yes _____
When: _____ Diagnosis:_____

Is there anything you would like to work on to improve your health?

Please respond if you have one of the following conditions:

High Cholesterol	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A
Diabetes	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A Most recent home glucose readings:
High Blood Pressure	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A Most recent home blood pressure readings:
Depression	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A Any suicidal thoughts? ☐ No ☐ Yes ☐ N/A

Have you been to the emergency room, hospital or any other provider since your last visit?
If yes, please explain:

Have you been diagnosed with any of the following since your last visit?
If yes, please check:

☐ Cardiac Murmurs	☐ Abnormal EKG	☐ Sleep Apnea	☐ Diabetes
☐ Hypertension	☐ Angina Pectoris	☐ Coronary Artery Disease	☐ Mitral Valve disorder
☐ Tricuspid valve disorder	☐ Pulmonary valve disorder	☐ Atrial-Fib	☐ Atrial-Flutter
☐ Heart Failure	☐ Cardiomegaly		

Are you experiencing any of the following?

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

Lifestyle

Alcohol

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week
☐ 4 or more times per week

How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Caffeine

Do you consume any caffeine? ☐ No ☐ Yes: How often?	How much?

Exercise

Do you exercise? ☐ No ☐ Yes: How often?	How long?

Smoking

Do you smoke? ☐ No ☐ Yes: How often?	How much?

Birth control

Do you use any form of birth control? ☐ No ☐ Yes: What method?

Medication adherence

Do you have trouble taking any of your medications? ☐ No ☐ Yes: Describe.

Are there any changes to your family medical history? For example, if a family member has received a new diagnosis, we can update your family history to reflect any changes since your last visit.

Have you recently developed an allergy to any of your medications? If yes, please describe below.

Do you have any end-of-life care plans or preferences? If yes, please bring a copy of relevant documents to your upcoming visit (e.g., your advance directive, power of attorney and health care proxy). If not, would you like to discuss your preferences?

Disease Prevention Screening:

Sleep Apnea

Has anyone told you that you snore loudly or stop breathing when asleep? ☐ No ☐ Snoring loudly (heard from another room) ☐ Stop Breathing

Skin Cancer

When did you last have a full-body skin cancer check by a medical professional? ☐ I don't know ☐ Month/Year_____

Colon Cancer- Adults over 50

Have you had a colonoscopy or other colon cancer screening? ☐ No ☐ Yes: When?

Women

When was your last PAP smear? ☐ I don't know ☐ Month/Year_____

Women Over 40

Have you had a mammogram? ☐ No ☐ Month/Year_____

Women Over 65

Have you had a bone density test? ☐ No ☐ Month/Year_____

Diabetes Management:

When did you last have your diabetic bloodwork done? ☐ I don't know ☐ Month/Year_____
When did you last visit your eye doctor? ☐ Never ☐ I don't know ☐ Month/Year_____
When did you last visit your podiatrist? ☐ Never ☐ I don't know ☐ Month/Year_____

Do you have any other concerns? If yes, please describe below.