Name: _____

Date: _____

Oahu Osteopathic Clinic

1150 S. King St., Suite # 906
Honolulu, HI 96814-1953
Office: (808) 468-2461 Fax: (808) 441-1974

admin@feelgoodoahu.com

DO YOU HAVE ANY OF THESE SYMPTOMS?

Fever/chills	Yes	No	Chest pressure or pain	Yes	No
Fatigue	Yes	No	Difficulty breathing	Yes	No
Unplanned weight loss	Yes	No	Cough or wheeze	Yes	No
Dizziness	Yes	No	Headache	Yes	No
Hearing loss or other problems	Yes	No	Neck, back, or joint pain	Yes	No
Sinus or allergies	Yes	No	Arm or leg pain	Yes	No
Thyroid problems	Yes	No	Loss of motion	Yes	No
Abdominal pain	Yes	No	Numbness or tingling	Yes	No
Nausea/vomiting	Yes	No	Anxiety	Yes	No
Diarrhea/constipation	Yes	No	Depression	Yes	No
Burning urination	Yes	No	Other or additional concerns (fill in)		
Frequent urination or leakage	Yes	No			

Oahu Osteopathic Clinic Intake Form

Name: _____ Date: _____

What name would you like to be called? _____

Address:_____

_____

Phone #: (____) ____-_____ E-mail: _____

Birthday: ____ /____ /_____ Height: _____ Weight: _____

What brings you in today? _____

_____

Is your problem due to an auto accident or injury at work? Y or N

Do you enjoy life? Y or N Are you depressed? Y or N

If you have pain, on a scale of 1 to 10, what number is your pain? _____
In your family, did your parents, brother, or sister have any of the following diseases: Diabetes, Heart disease, Cancer, Stroke: _____

_____

_____

Are there any diseases that run in the family? Y / N What are they?

_____

Please give us a person to notify in emergency. Name: _____
Relation to you: _____ Phone # (_____) _____-_____
Address: _____

_____

Who is your current Primary Care Doctor? Name: _____
Address: _____

_____

Phone #: (____)_____-_____ Fax #: (____) _____-_____

Oahu Osteopathic Clinic Intake Form

Name: _____ Date: _____

Do you have any chronic medical problems? Y or N What are they?

_____

What medications are you taking, what are the doses and how often?:

_____

_____

What surgeries have you had and when?

_____

Are you allergic to anything? Y or N What happens if you are exposed?

_____

What do/did you do for a living?:

_____

What exercises do you engage in on a weekly basis? _____

_____

Do you now or have you ever used tobacco. Y / N How much for how long?

_____

How many alcoholic drinks do you have in a week? _____
Have you ever done street drugs? Y / N If so , what?

_____

How would you prefer to be notified about upcoming appointments?
Email_____ Text Message_____ Phone Calls_____

How did you hear about us?

_____

·HIPAA Notice of Privacy Practices Statement

Notice of Information Practices and Privacy Statement
For OAHU OSTEOPATHIC CLINIC
1150 S. King St., Suite #906, Honolulu, HI 96814
Phone: (808) 468-2461 Fax: (808) 441-1974
Email: admin@feelgoodoahu.com

How We Collect Information About You: Oahu Osteopathic Clinic and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between Oahu Osteopathic Clinic and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.feelgoodoahu.com) that simply records the number of visitors and no other data.

We do use some affiliate programs that may or may not capture traffic date through our site. To avoid potential data capture that you visited any other websites, simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Oahu Osteopathic Clinic. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Patient Name	Patient Signature	Date

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
   - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
   - Co-payments are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit.
   - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**
   I hereby authorize and direct payment of my medical benefits to Oahu Osteopathic Clinic on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**
   I hereby authorize Oahu Osteopathic Clinic to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. **MEDICARE REQUEST FOR PAYMENT**
   I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Oahu Osteopathic Clinic . I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party | Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party | Relationship to Patient

Oahu Osteopathic Clinic

1150 S. King St., Suite # 906
Honolulu, HI 96814-1953
Office: (808) 468-2461 Fax: (808) 441-1974

admin@feelgoodoahu.com

Consent for Osteopathic Procedure

Side effects from manipulation can sometimes happen. Most common are stiffness and soreness. Treatments are tiger balm or Deep Heat to the site. Drink lots of water. Heat helps, especially if you can soak in hot water. Over the counter pain medications can help if your doctor says they are safe for you to take. Leaning into the pain can help. Please remove all metal, belts, jewelry. No jeans, natural materials are best for your clothes.

_____ _____

(Patient name) (Signature)

_____

(Date)