Referral Date: _____
Appt. date: _______
Appt. time: _______
Therapist: ________

Mililani Physical Therapy, LLC
and Massage Center

Name: ____________________________________ **Phone**(H): ____________________
(C): ____________________
(W): ____________________

Address: ___________________________________
City: _____________________, **Zip Code:** ________

In Case of Emergency: ________________ **Relationship:** ______________ **Ph:**____________

How did you learn about our services? __ Window sign __ newspaper Ad __ Other
__ Family/friend (Referred by ________________)

Requested area(s) to be worked on:

____

____

General Information:

1. Is this your first massage? Y N

2. Are you pregnant? If yes, how many months? _____ Y N

3. Do you have epilepsy? Y N

4. Do you have high or low blood pressure? Y N

5. Are you diabetic? Y N

6. Do you have cancer? If yes, what type? ___________ Y N

7. Have you had any surgeries or injuries in the past 2 years? Y N
   If yes, please explain: ____________________________
   ____

8. Other medical problems you would like us to know: ________________________________
   ____

9. Are you taking any medications? If yes, please list: ________________________________
   ____

10. Do you have any allergies? If yes, please list: ____________________________________
    ____

MILILANI PHYSICAL THERAPY, LLC

CONSENT OF DISCLOSURE

(For the Usage and/or Disclosure of Protected Health Information)

I hereby give consent to **Mililani Physical Therapy, LLC** and all health care providers furnishing care within **Mililani Physical Therapy, LLC's** facility to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment, or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by requesting so from our Privacy Compliance Officer Mary Lau-Miki.

Print Name of Patient: ____
Signature of Patient: ________________________________ Date: ____________

If you are signing as the patient's representative:
Relationship: ____
Print Your Name: ____

CANCELLATION

I hereby void the consent given above.
Print Name of Patient: ____
Signature of Patient: ________________________________ Date: ____________

If you are signing as the patient's representative:
Relationship: ____
Print Your Name: ____

Address for cancellation: Your cancellation will be effective, upon receipt, at the following address:

Mililani Physical Therapy, LLC
95-720 Lanikuhana Avenue #140
Mililani, HI 96789

02/08

Mililani Physical Therapy, LLC
Massage Therapy Waiver

Please review and initial the following:

_____ I agree to be registered as a guest of Mililani Physical therapy, LLC and voluntarily consent to the massage therapy procedures provided.

_____ I understand that the purpose of the massage therapy session that I receive at Mililani Physical Therapy, LLC is to assist with the relief of muscular tension/stress and pain. It may also assist in improving circulation, joint mobility and function.

_____ I acknowledge that the therapist at Mililani Physical Therapy, LLC do not diagnose medical conditions.

_____ I understand that the massage therapy treatments are not a substitute for medical treatments.

_____ I have notified my therapist of all my known medical conditions or problems.

_____ I release Mililani Physical Therapy, LLC and its therapists from all claims listed above.

_____ I agree to pay the amount of the service in accordance with the listed rates of Mililani Physical Therapy, LLC at the completion of services received per session.

_____ I understand that I will be charged a $25.00 fee for "no shows" or cancellations (less than 3 hours prior to scheduled appointment), unless it due to 1) death in the family, 2) medical illness with a MD note, or 3) a family emergency.

The undersigned certifies that he/she has read and understood the foregoing, and accepts its terms.

______________________	____________	______________________
Signature of Client	Date	MPT Witness