Contact Information

Name ______________________ Date ____________

Birthdate ____________ Gender *M* *F* Occupation ____________

Address ______________________

City ____________ State ______ Zip code ______

Email ____________ Primary phone ____________ Other phone ____________

Preferred communication
(check all that apply)

- ❑ *Voicemail*
- ❑ *Text*
- ❑ *Email*

Emergency contact/relationship ______________________ Phone ____________

Primary care physician ______________________ Phone ____________

Referral physician (if different) ______________________ Phone ____________

How did you hear about **MŌHALU Therapy**? ______________________

SYMPTOMS AND TREATMENT

Primary complaint/reason for visit: ______________________________

____

Describe your present symptoms. ______________________________

____

What caused your symptoms? ______________________________

____

How have your symptoms
gotten better or worse? ______________________________

____

What conditions make your
symptoms get better or worse? ______________________________

____

How do your symptoms affect your
job or other aspects of your life? ______________________________

____

Describe family members' similar or other symptoms. ____________________

____

What strategies have you used at home to work on these symptoms? ____________________

____

Describe any serious accidents. ____________________

____

Describe any chronic illnesses. ____________________

____

Describe any hospitalizations. ____________________

____

Describe surgeries or illnesses related to your symptoms. ____________________

____

Do you have any difficulties with your hearing or any disabilities? ____________________

____

jill@mohalutherapy.com
512-417-8599

Do you have a history of the following? *(check all that apply)*

- ❑ Cardiac pacemaker
- ❑ Circulation disorder
- ❑ Osteoarthritis
- ❑ High/low blood pressure
- ❑ Depression
- ❑ Headaches/Migraine
- ❑ Cancer
- ❑ Osteoporosis/Osteopenia
- ❑ Congestive heart failure
- ❑ Vertigo/Dizziness
- ❑ Diabetes
- ❑ Heart disease/Stroke
- ❑ Rheumatologic disorder
- ❑ Asthma
- ❑ Other ________________

List current medications and reason(s) prescribed.

____

____

____

Describe your allergies or sensitivities (e.g. latex, lotion, scents, foods, medications).

____

____

____

List the places where you've had previous evaluation or therapy (e.g. speech pathologists, physicians, other professionals)

Name	Address	Date(s)
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Treatment Guidelines and General Information

Please read this section and sign the final page. If you have any questions or concerns, please let me know at or before your first appointment.

What to have for your 1st visit.

For your first visit, have (1) a speech therapy script or physician order, if you have one; (2) copies of any imaging studies related to your treatment; and (3) this completed packet, unless you emailed it back to me.

Communication.

You benefit the most from our relationship when you ask questions or candidly tell me about your symptoms, progress, or concerns. Whether paper or electronic, your files will be stored in a safe and secure manner. I will send information to you electronically, unless you request otherwise. To communicate efficiently, I may email, text, or call based on your preferences. These technologies may not be secure, so by signing below, you waive any objection to communication between us via these methods.

Cancellations and Missed Appointments.

If you need to change or cancel an appointment, I appreciate as much notice as possible so I can offer your appointment time to another patient on the waiting list. I require at least 24 hours' notice for all cancellations and schedule changes. Otherwise, you'll be charged in full for the missed appointment. Also, if you're more than 15 minutes late for your appointment, I have the right to cancel the appointment and charge in full for the missed appointment. And I may put your services on hold if you don't attend, cancel, or arrive 15 minutes late for 3 sessions in a row.

Payment and Insurance.

Full payment is due before each session. MŌHALU Therapy doesn't contract with any insurance companies and therefore is an out-of-network, non-participating provider. However, **except for Medicare**, you may be reimbursed by your insurance company, depending on your plan. Please contact your insurance company or employer for information about how to submit a claim or proof of payment for HSA or FSA reimbursement.

Privacy.

MŌHALU Therapy protects your privacy and only uses or discloses your confidential health information (in verbal or written form) for services or treatment; reporting, collaborating, or communicating with your physician(s) or other treatment provider(s); administrative activities; or payment. Your personal health information may be disclosed without prior authorization in an emergency or when required by law. In all other situations, your written authorization or consent will be obtained before your personal health information is disclosed. If you give written authorization, you may later revoke that authorization at any time or for any

reason. You have a right to obtain a copy of your personal health information at any time, or request that inaccurate or incomplete information be corrected.

I read, understand, and voluntarily agree to these Treatment Guidelines. I voluntarily consent to evaluation, care, and treatment by MŌHALU Therapy, as recommended or as prescribed by my physician or provider. I understand my right to ask questions, stop treatment, or receive information about the purpose, benefits, risks, or alternatives to treatment. Although treatment is usually beneficial, I acknowledge that no guarantees or promises about results or outcomes have been made to me because treatment is not an exact science. I accept responsibility for candidly communicating about my health, medications, allergies, symptoms, treatment, or progress. I give permission to MŌHALU Therapy to use or release my personal health information for services or treatment; reporting, collaborating, or communicating with my physician(s) or other treatment provider(s); administrative activities; or payment. I understand that I am responsible to pay for my treatment, and I have information about service fees.

Patient Signature: ____

Date: ____

Thank you for choosing

I look forward to working with you!

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