LIZA MANIQUIS-SMIGEL MD, LLC
Physical Medicine & Rehabilitation
Spine, Sports, Electrodiagnostic Medicine, Prolotherapy, Platelet Rich Plasma, Stem Cell
136A Ululani St, Hilo Hawaii 96720 Phone: (808) 933-3444 Fax: (888) 383-4766

PATIENT REGISTRATION (Please Print Clearly)

Referring MD: ____ Today's Date: __________________________

Patient Name: ____
LAST FIRST MIDDLE

Date of Birth: _______/_______/________ Age: ________________ Male or Female

Social Security Number: ________-________-________ E-Mail Address: ______________________________

Mailing Address: ____

Physical Address: ____

Phone: Mobile: __________________________Home: _______________________ Work: ______________________

In Case of Emergency: _______________________________________ Relationship: __________________________

Address: ____ Phone: ________________________

INSURANCE AND FINANCIAL RESPONSIBILITY (Receptionist will copy your insurance card)

Type of Insurance: _______________________________ Are these visits covered by Medical Insurance: _______

Responsible party (If other than patient or if patient is a minor/dependent)

Name: ____ Relationship to Patient: __________________________

Address: ____ Phone: _________________________

Date of Birth: ______/_______/________

Please circle if AUTO ACCIDENT or INDUSTRIAL (WORK) ACCIDENT and complete the following information:

Date of Accident: ______/______/________ Insurance Company: __________________________________

Policy or Claim Number: ________________________________ Adjustor: ______________________________

Insurance Company Address: ____Phone: __________________

If work injury – Employer: ____ Supervisor: ______________________
Address: ____ Phone: _________________________

PATIENT AFFIRMATION AGREEMENT AND AUTHORIZATION

- The foregoing questions are true and correct to the best of my knowledge
- I acknowledge and understand that I am responsible for all of the services rendered to me or my dependent family member by Liza Maniquis-Smigel M.D. LLC. I agree to pay promptly upon receipt of the monthly statement
- I hereby authorize payment of medical benefits on my behalf to be made directly to Liza Maniquis-Smigel M.D. LLC for services rendered
- I voluntarily consent to have Liza Maniquis-Smigel M.D. provide medical care, including diagnostic and treatment procedures deemed necessary to aid and assist in the diagnosis and treatment of myself or my dependent family member

Signature: ____ Date: _________________________

AGREEMENT TO RELEASE CONFIDENTIAL INFORMATION

I understand and agree that Liza Maniquis-Smigel M.D. LLC will keep any and all information regarding my medical condition confidential within the laws of the HIPAA Privacy Act. Written consent must be obtained from me for disclosure of my medical information to any person or entity other than my referring physician, another medical facility to which I may be referred by Liza Maniquis-Smigel M.D. LLC or the party(ies) obligated to pay for said services

Signature: ____ Date: _________________________

MEDICARE AUTHORIZATION (MEDICARE PATIENTS ONLY)

I request that payment under the MEDICARE insurance program be made directly to Liza Maniquis-Smigel M.D. LLC for any medical services provided during the effective period of this authorization. I authorize Liza Maniquis-Smigel M.D. LLC to release to the Social Security Administration or its intermediaries or carriers any information necessary for this claim or any related Medicare claim. I authorize the use of a copy of this signed agreement to be used in place of its original

Signature: ____ Date: _________________________

PRESCRIPTION POLICY

Regular follow up visits with Liza Maniquis-Smigel M.D. are necessary for continuation of prescription medications. In some cases, refills may be approved by Liza Maniquis-Smigel M.D. between follow up visits. Please plan ahead, as any approved refills require at least a 24-hour (one working day) notice to process for both written or call-in prescriptions

Signature: ____ Date: _________________________

NOTICE OF PRIVACY PRACTICE (NPP)

I have received the Notice of Privacy practice and acknowledge the opportunity to review the NPP as provided by HIPAA regulations

Signature: ____ Date: _________________________

If patient is unable to provide written acknowledgement, please check reason

Communication Barrier ___________________ Refusal __________________ Other ____________________________

LIZA MANIQUIS-SMIGEL M.D. LLC

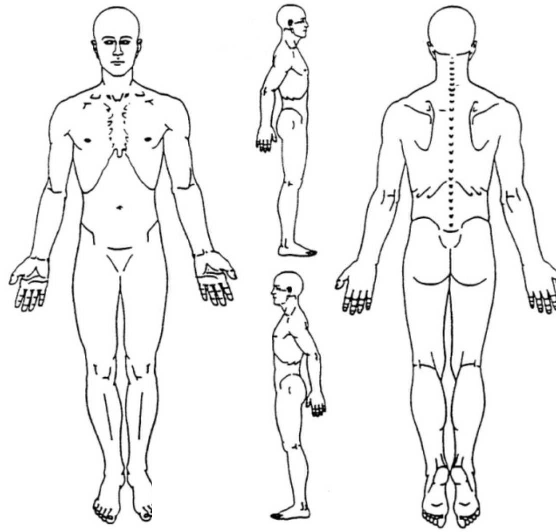
NEW PATIENT QUESTIONNAIRE

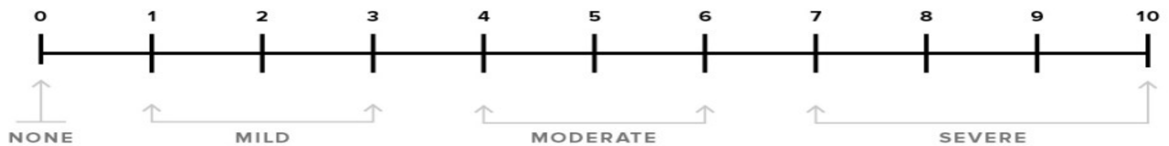
Name: ____ Date of Birth: ______________________ Age: __________________

Employer/Position: ____ Height: _____________ Weight: _______________

What is your chief complaint: ____

Use the picture below to shade/circle where your pain/problem occurs





When did you first notice the problem beginning (approximate): ____

Was there an incidence of trauma or accident: ____

How much time each day do you experience pain (100%, 75%, not every day): ____________________________________

Circle what best describes the pain: Dull Sharp Achy Shooting Cramping Nagging Burning
Pins & Needles (Tingling) Stabbing Other _______________________

What are relieving factors for the pain: ____

What activities aggravate or make your pain worse: ____

Did you lose strength & sensation (describe): ____

Please list all the doctors that you have seen for this problem: ____

List any diagnostic imaging done (X-RAY, MRI CT) and where: ____

Have you had any operations or procedures for this problem: ____

Have you had any physical therapy for this problem (where): ____

Please circle any physical activity you are involved in:

Walking/Hiking	Aerobic/Dancing	Jogging/Running	Rowing/Canoeing	Tennis/Racket Sports
Swimming/Surfing	Bicycling	Weight Lifting	Stretching	Other_______________

List the activities with which your problem has interfered, including daily activity ___________________________________
____

Past Medical History (Please circle):

None	Arthritis	Diabetes	High Blood Pressure	Stroke	Asthma/TB	
Hyper/Hypo Thyroid	Stomach Problems		Female Problems	Cancer	Heart	Psychiatric

Surgical History (Please list and date): ____
____

List **ALL** Medications: ____

____

List Allergies and Reactions: ____

Family History:	Father	Mother	Brothers	Sisters
CVA or Stroke	_____	______	_______	_____
High Blood Pressure	_____	______	_______	_____
Diabetes	_____	______	_______	_____
Cancer	_____	______	_______	_____
Arthritis	_____	______	_______	_____
Other	_____	______	_______	_____

Social History:

Where do you live: ________________________________ Who do you live with: ______________________

How many children do you have: ____

Do you smoke/how many: _________________________ Do you drink alcohol: _______________________

Review of Systems:

How do you view your current health (please circle):

Excellent Good Fair Poor

Current Problems Include (please circle all that apply)

Hand/Arm	Shoulder	Back	Neck	Hip	Thigh/Leg	Feet/Ankle	Skin	Headaches
Weight	Sleep	Fatigability	Diarrhea/Constipation			Depression/Anxiety		Dizziness
Breathing	Urinary Sexual							

Signature: ____ Date: ______________________________

CANCELLATION AND NO-SHOW POLICY

We understand situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you must provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other people.

Office appointment which is cancelled with less than 24 hours notification may be subject to a $25.00 cancellation fee and $75.00 for cancellation of a procedure.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered a NO SHOW. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a $25.00 fee for office appointment No Show and $50.00 procedure No Show fee.

The cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the billing department (808)933-3444.

Please sign that you have read, understand and agree to this cancellation and now show policy.

Print Name: ____ Date of Birth: __________________

Signature: ____ Today's Date: __________________