The physician for your workers' compensation claim has referred you to see Dr. Chester.

Please complete pages 3, 4 and 5.
Return pages 3, 4 and 5 to our office by fax or mail.
Our office will call you to schedule your appointment. Thank you.

Our contact information:

Dr. Jeffrey H. Chester, DO
Puuone Plaza Building
1063 Lower Main St, Suite C212
Wailuku, HI 96793-6006
808-249-8887 (phone)
808-249-8889 (fax)
www.ponohealthcare.com
drchester@ponohealthcare.com

JEFFREY H. CHESTER, DO
1063 Lower Main St, Suite C212
Wailuku, Maui, Hawaii 96793

Privacy Policies Notice

It is the policy of my practice and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that my practice and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to my practice and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, my practice and staff will--

- ☞ Adhere to the standards set forth in the Notice of Privacy Practices.
- ☞ Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. My practice and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- ☞ Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- ☞ Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. My practice and staff will
  - ➢ Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- ☞ Recognize that patients have a right to privacy. My practice and staff respect the patient's individual dignity at all times. My practice and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- ☞ Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, My practice and staff will:
  - ➢ Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - ➢ Not disclose PHI data unless the patient (or their authorized representative) has properly authorized the release or law otherwise authorizes the release. Recognize that, although my practice "owns" the medical record, the patient has a right to inspect and obtain a copy of their PHI. In addition, patients have a right to request an amendment to their medical record if he/she believe their information is inaccurate or incomplete. My practice and staff will--
  - ➢ Permit patients access to their medical records when their written requests are approved by my practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
  - ➢ Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- ☞ My practice and staff will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- ☞ My practice and staff will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- ☞ My practice and staff must adhere to this policy. My practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- ☞ My practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

PATIENT INFORMATION FORM

All information provided is confidential.

LAST NAME:____

FIRST NAME AND MIDDLE INITIAL:______________________________

PHYSICAL ADDRESS (required):______________________________

____

MAILING ADDRESS (if different from above):________________________

____

GENDER: ❑ Male ❑ Female ❑ Trans* ❑ ____________________

DATE OF BIRTH (month/date/year):____________________

HOME PHONE: ____

CELLULAR PHONE:____

WORK PHONE:____

WHICH PHONE NUMBER(S) CAN OUR OFFICE LEAVE CONFIDENTIAL MESSAGES FOR YOU? (check all which apply)
❑ Home ❑ Cellular ❑ Work

EMPLOYER:____

OCCUPATION:____

EMERGENCY CONTACT NAME: ______________________________

EMERGENCY CONTACT PHONE NUMBER:________________________

EMERGENCY CONTACT RELATIONSHIP TO PATIENT:____________________

IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE), PLEASE PROVIDE PARENT/GUARDIAN INFORMATION:

NAME OF PARENT OR GUARDIAN:______________________________

PARENT/GUARDIAN PHONE NUMBER:______________________________

ADDRESS (IF DIFFERENT FROM PATIENT):________________________

"Privacy Policies Notice"Acknowledgment:
I have read, understand and received a copy of Jeffrey H. Chester, DO's "Privacy Policies Notice."

____

Signature of Patient or Guardian Today's Date

FINANCIAL / INSURANCE INFORMATION FORM

PRINT YOUR FULL NAME:______________________________

WORKERS' COMPENSATION (W/C) INSURANCE:______________________________

DATE OF WORK-RELATED INJURY:______________________________

NAME OF PHYSICIAN FOR W/C CLAIM:______________________________

NAME OF ATTORNEY FOR W/C CLAIM:, if any:______________________________

NAME OF CLAIMS ADJUSTER FOR W/C CLAIM:, if known:______________________________

PHONE NUMBER OF CLAIMS ADJUSTER FOR W/C CLAIM, if known:______________________________

I hereby authorize my insurance carriers to pay and hereby assign directly to Dr. Jeffrey H. Chester all benefits, if any, otherwise payable to me for services. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for myself and/or dependents, and that I will be bound by my signature as though the undersigned had personally signed the particular claim.

________ Initial **Appointment Cancellation Policy:** Please call our office at least 48 hours before the date of your appointment, if you must cancel or reschedule your appointment with Dr. Chester. There is a $300 fee for broken appointments.

________ Initial I understand that Dr. Chester may forward medical notes related to my medical care to other healthcare providers, like my primary care physician, referring physician, psychologist, and/or physical therapist, unless I request in writing that Dr. Chester may not discuss my medical care with certain individuals. Our office will never share, sell, or rent your personal information to anyone for marketing purposes.

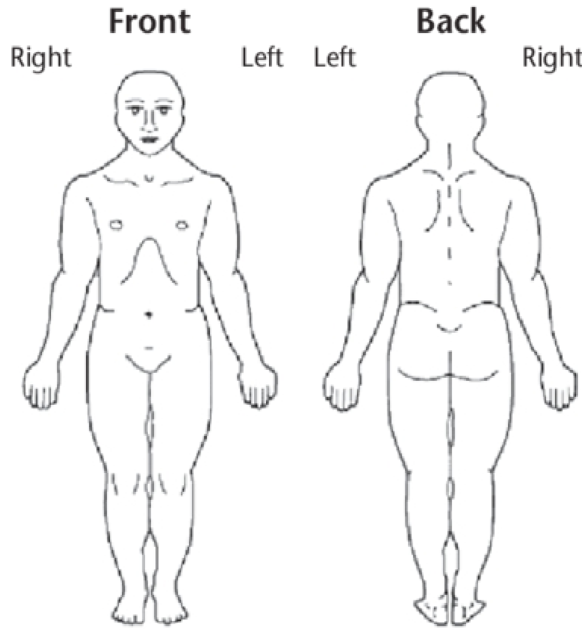
____

Signature of Patient or Guardian Today's Date

PRINT YOUR FULL NAME:____

TODAY'S DATE:____

On the diagram, below, shade in the areas where you feel pain. If you have more than one area, circle the area that bothers you the most.



Mark 'Yes' to the following items that describe your pain over the past week and 'No' to the ones that do not.

Question	Score	
	Yes	No
1. Did the pain feel like pins and needles?	1	0
2. Did the pain feel hot/burning?	1	0
3. Did the pain feel numb?	1	0
4. Did the pain feel like electrical shocks?	1	0
5. Is the pain made worse with the touch of clothing or bed sheets?	1	0
6. Is the pain limited to your joints?	–1	0

Total score = 3–5: 69% probability of NeP (using c-index)

MUSCLE AND NERVE TESTING

How do I prepare for the test?

- Continue all of your usual medicines. Bring your medicine list or bottles with you.
- Eat and drink normally. If you are diabetic or have "low blood sugar," bring a snack.
- Wash with soap and water.
- **DO NOT** use skin lotions, skin creams, moisturizers, or sun block.   It will interfere with the test.
- Wear shorts, short sleeves and/or any clothing that will allow for easy access to most body areas, including your arms, legs, back and neck.
- Feel free to bring a relative or friend with you.
- You may bring a music CD to your appointment.

Who performs the test?

Dr. Chester performs all of the testing.

What is the test like and how long does it take?

- All testing is done in a private room while you are sitting or lying down.
- Most testing can be completed within one hour.
- Small breaks of 4 to 5 minutes are not usually required, but are possible during the test.
- There are usually two parts to the test:
    1. Nerve flow testing – a small amount of electrical current to "stimulate" the nerves.
    2. Muscle testing – a very thin needle into certain muscles to record nerve and muscle interaction.

What are the risks?

PROBLEMS ARE VERY RARE AND THE RISKS ARE VERY SMALL. A thin needle for the muscle testing is usually needed, so the risk of bleeding and infection is possible. If there are any other risks, Dr. Chester will tell you before he begins.

What do I do after the test?

You may go about your normal life after your appointment. Take all your medicines as prescribed. A detailed note regarding the test will be sent to your doctor. If you feel any discomfort, have any questions or concerns during normal business hours, please call our office at 808-249-8887. If you are unable to reach us, and it is an emergency, dial 911.