Thank you for contacting Dr. Jeffrey H. Chester's office.
Please follow these steps if you would like to become a patient in Dr. Chester's medical practice.

Step 1: Please call our office to find out if we are currently participating with your medical insurance.
Step 2: Keep this page, along with the "Privacy Policies Notice" for your records.
Step 3: Complete pages 1 – 8 and return them to our office by fax, email, or US Postal mail.
Step 4: Our office will call you after Dr. Chester has finished reading your paperwork and any prior medical records he may need to review.

Our contact information:
mailing address:
Dr. Jeffrey H. Chester, DO
Puuone Plaza Building
1063 Lower Main St, Ste C212
Wailuku, HI 96793-6006

phone: 808-249-8887
fax: 808-249-8889
website: www.ponohealthcare.com
email: drchester@ponohealthcare.com

1063 Lower Main St, Ste C212
Wailuku, HI 96793-6006
www.ponohealthcare.com

JEFFREY H. CHESTER, DO
Board Certified by American Board of Physical Medicine & Rehabilitation
Board Certified by American Board of Addiction Medicine
Certified in Addiction Medicine by the American Board of Preventative Medicine

Phone 808.249.8887
Fax 808.249.8889
drchester@ponohealthcare.com

Physiatry/Pain Management/Electrodiagnostic Medicine/EMG/Osteopathic Manual Medicine/Addiction Treatment

PRIVACY POLICIES NOTICE – your copy

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

INSTRUCTIONS: PLEASE PRINT WITH BLACK OR BLUE INK
ALL INFORMATION IS CONFIDENTIAL

LAST NAME:_____

FIRST NAME AND MIDDLE INITIAL:_____

PHYSICAL ADDRESS (required):_____

_____

MAILING ADDRESS (if different from above):_____

_____

GENDER: ❑ Male ❑ Female ❑ Trans* ❑ _____

SOCIAL SECURITY NUMBER (last four digits): XXX-XX-_____

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 AND POLICIES FORM

PLEASE LIST ALL YOUR CURRENT MEDICAL INSURANCES:

PRIMARY INSURANCE_____ MEMBER #_____

SECONDARY INSURANCE_____ MEMBER #_____

TERTIARY INSURANCE_____ MEMBER #_____

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.

Please initial your understanding of each statement:

_____ I understand I am financially responsible for all charges incurred, whether or not paid by my medical insurance. I also acknowledge that any insurance benefits when received by and paid to Dr. Jeffrey H. Chester will be credited to my account, in accordance with the above said assignment. If I have not met my insurance's deductible and/or if I have a copay/copayment associated with my medical services, I understand I am financially responsible. Accounts with outstanding balances may have interest applied at the rate of 1.5% every 30 days until the balance is repaid. Account balances more than 90 days old, may be forwarded to a collections agency, and an additional $50 (fifty dollar) administrative fee added to the account.

_____ I understand that any payments and/or copays/copayments related to my medical services are due and collected on the date of service. Any copay/copayment not paid on the date of service will incur a $10 administrative fee. Checks returned unpaid by the bank for insufficient funds will incur a minimum $30 service fee.

_____ Reminder calls are courtesy only. Our office does not overbook appointments.
To avoid a fee from a missed appointment, canceling or rescheduling your appointment with less than 24 hours notice, you must contact our office more than 24 hours from your scheduled appointment's date/time. Our voicemail is available 24/7, and will timestamp your call. The penalty for a broken appointment is $100.
Please note: if you missed your appointment because you were admitted to the hospital, please provide a copy of your hospital discharge summary to have your fee waived.

_____ Dr. Chester's office may charge an administrative fee to process the following: prior authorizations for medications; forms or documents which require Dr. Chester's review and signature; medication prescriptions which need to be re-written because the original was lost, stolen, misplaced, expired, or partially-filled.

_____ 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.

_____
Printed Name of Patient

_____
Signature of Patient or Guardian Today's Date

If you are accepted into the medical practice, you will be asked to present an original, current, government issued photo ID card and your insurance card(s) for verification.

PATIENT INITIAL EVALUATION SURVEY

Last Name | First Name | Middle Initial | Age | Today's Date

What medical condition would you like Dr. Chester to evaluate?_____

Did someone refer you to our office? _____

Have you seen another doctor for this condition? ❑ No ❑ Yes, their name is _____

Have you had any previous treatments for your current condition? Please check all that apply.

❑ No ❑ Medical ❑ Physical Therapy ❑ Chiropractic
❑ Massage ❑ Acupuncture ❑ Psychology ❑ Other _____

Have you had any X-Rays, MRIs, nerve testing, blood tests, or other tests for your current condition?

❑ No ❑ Yes, I have had_____

List each body part which has pain. If you would like to be seen for addiction treatment only, you may skip this section.

BODY PART 1: _____ ❑ Pain is constant ❑ Pain comes & goes: how often? _____

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

no pain **mild** **moderate** **severe** **worst pain I can imagine**

BODY PART 2: _____ ❑ Pain is constant ❑ Pain comes & goes: how often?_____

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

no pain **mild** **moderate** **severe** **worst pain I can imagine**

BODY PART 3: _____ ❑ Pain is constant ❑ Pain comes & goes: how often?_____

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

no pain **mild** **moderate** **severe** **worst pain I can imagine**

Do you have problems with any of the following? Please check all that apply.

□ sitting
□ standing
□ walking
□ running
□ bending
□ stooping/squatting
□ twisting
□ getting to or from a bed or chair
□ reaching
□ gripping
□ lifting
□ carrying
□ writing
□ typing/computer use
□ using arms
□ dressing
□ grooming
□ using the toilet
□ cooking
□ cleaning
□ household chores
□ driving
□ shopping
□ sleeping
□ taking care of another person
□ sports/hobbies
□ sexual activity
□ learning
□ thinking
□ reasoning
□ concentration
□ socializing

Do you have any of the following? Please check all that apply.

□ numbness/tingling: _____
□ new weakness: _____
□ falls/clumsiness
□ recent cold/flu
□ fevers
□ chills
□ night sweats
□ unplanned weight loss
□ pain that wakes you up
□ trouble sleeping
□ sexual dysfunction
□ black/bloody stools
□ diarrhea
□ heartburn/nausea
□ painful urination
□ frequent urination
□ other problems with bowels/bladder
□ fainting/blackouts
□ lack of appetite
□ stiffness of joints: _____
□ swelling of joints: _____
□ swollen ankles
□ leg cramps
□ swollen glands
□ change in vision
□ change in hearing
□ change in taste
□ change in smell
□ change in speech
□ chest pain
□ cough
□ shortness of breath
□ headaches
□ difficulty swallowing
□ itching/rash/skin changes
□ nail/hair changes
□ fatigue/tiredness
□ depressed mood
□ anxiety/nervousness

Do you have any of the following? Please check all that apply.

□ surgery:_____
_____
□ heart disease
□ diabetes
□ high / low blood pressure
□ high cholesterol
□ anemia/low blood count
□ bleeding problems
□ lung disease / tuberculosis
□ cancer:_____
□ bone disease
□ fractures:_____
□ joint dislocation:_____
□ arthritis:_____
□ thyroid problem
□ hormone problem
□ poor circulation
□ foot problems
□ head injury
□ eye problems
□ skin problems
□ exposure to chemicals / sun / asbestos
□ ulcer
□ stomach / intestine problems
□ liver problems / jaundice
□ kidney stones / kidney disease
□ bladder/urine problem
□ prostate problem
□ testicular disease / removal
□ ovarian disease / removal
□ uterine disease / removal
□ breast disease / removal
□ HIV / AIDS
□ addiction:_____
□ miscarriage
□ sexually transmitted diseases
□ back pain
□ nerve / spinal cord problem
□ scoliosis
□ multiple sclerosis
□ Parkinson's disease
□ seizures
□ stroke
□ aneurysm
□ childhood diseases
□ child abuse
□ depression
□ anxiety disorder
□ other mental illness
□ other injury / trauma
□ other:_____

What are your current medicines <u>and</u> their dosages (include prescription, over-the-counter, supplements, oral contraceptives, and hormone replacement):

❑ I am not currently taking any medications.

❑ I am taking the following medications, supplements, and/or vitamins: _____

_____

_____

Do you have any allergies? Please include medicines, food, seasonal, other.

❑ No ❑ Yes, _____

Approx. Height _____ft _____in Approx. Weight _____lbs

For Women: To the best of your knowledge, could you be pregnant? ❑ No ❑ Yes (please inform Dr. Chester when you see him.)

Do you chew or smoke tobacco? e-cigs? vape? ❑ No ❑ Yes (what? how many? how often?) _____

Do you drink alcohol (beer, wine, liquor)? ❑ No ❑ Yes (what? how much? how often?) _____

Do you use any illegal or illicit drugs? ❑ No ❑ Yes (what? how much? how often?) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Who do you live with? _____

Are you working? ❑ No ❑ Yes - your occupation / job: _____

❑ Full-time ❑ Part-time Regular Duties? ❑ Yes ❑ No

Name of your primary care physician (PCP):_____

Do any of the following diseases run in your family (parents, brothers, sisters, children)? Please check all that apply.

□ heart disease
□ high blood pressure
□ lung disease
□ arthritis
□ diabetes
□ cancer:_____
□ kidney stones / kidney disease
□ thyroid problem
□ hormone problems
□ stroke
□ bone disease
□ stomach/intestinal disease
□ multiple sclerosis
□ liver disease
□ skin disease
□ addiction
□ anxiety
□ depression
□ ovarian disease/removal
□ uterine disease/removal
□ breast disease/removal
□ testicular disease/removal
□ other: _____

INSTRUCTIONS: YOU MUST COMPLETE THIS PAGE. PLEASE READ EACH SECTION AND ANSWER THE QUESTIONS. THEN SIGN AND DATE THE BOTTOM OF THIS PAGE.

SECTION 1: IS YOUR CONDITION DUE TO A WORK-RELATED INJURY?

❑ NO *(If you answered "NO," go to Section 2)*

❑ YES, Date of work-related injury _____ Time of injury _____am / pm

Did your injury happen in Hawaii? ❑ Yes ❑ No Date supervisor was notified of injury_____

Date you last worked _____Supervisor's name: _____

Briefly describe how injury occurred, and which body parts were injured:_____

_____

Any other work-related injuries? ❑ No ❑ Yes:_____

SECTION 2: IS YOUR CONDITION DUE TO A MOTOR VEHICLE ACCIDENT?

❑ NO *(If you answered "NO," go to Section 3)*

❑ YES, Date of motor vehicle accident _____ Time of accident_____am / pm

Did your accident happen in Hawaii? ❑ Yes ❑ No

Briefly describe how accident happened: _____

_____

Were you the ❑ driver? ❑ passenger?

Were you wearing your seat belt? .....❑ No ❑ Yes

Did the air bags deploy?.....❑ No ❑ Yes

Was the vehicle damaged? .....❑ No ❑ Yes (what part of the car),_____

Did you hit your head? .....❑ No ❑ Yes

Did you brace yourself? .....❑ No ❑ Yes

Did you go to the Emergency Room (ER)? .....❑ No ❑ Yes

If "yes," were x-rays taken? .....❑ No ❑ Yes

If "yes," were blood tests done? .....❑ No ❑ Yes

If "yes," were you given medication? .....❑ No ❑ Yes, _____

Do you have nightmares about the accident? .....❑ No ❑ Yes

Are you nervous about driving?.....❑ No ❑ Yes

Are you nervous about being a passenger? .....❑ No ❑ Yes

Any other motor vehicle accidents?.....❑ No ❑ Yes (date, where & what happened),_____

_____

SECTION 3 - IS YOUR CONDITION DUE TO AN INJURY WHICH HAPPENED IN A PRIVATELY OWNED LOCATION? For example, you slipped and fell in a restaurant, supermarket, or mall parking lot?

❑ NO *(If you answered "NO," go to the bottom of this page to sign and date this page)*

❑ YES, Date of injury _____ Time of injury _____am/pm

Did this accident happen in Hawaii? ❑ Yes ❑ No

Briefly describe how injury occurred: _____

_____

IF YOU ANSWERED "YES" TO ANY OF THE SECTIONS ABOVE, PLEASE ANSWER THE FOLLOWING…

What is the status of your claim? ❑ Open ❑ Closed ❑ Settled w/Medical Open ❑ Funds Exhausted ❑ Pending ❑ Denied ❑ I Don't Know

Do you have an attorney or lawyer for your claim? ❑ No ❑ Yes, their name is_____

_____

Patient's Signature Patient's Name Printed Today's Date

1063 Lower Main St, Ste C212
Wailuku, HI 96793-6006
www.ponohealthcare.com

JEFFREY H. CHESTER, DO
Board Certified by American Board of Physical Medicine & Rehabilitation
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, authorize
Patient's Name Birth date Social Security Number

❑ ~~JEFFREY H. CHESTER, DO~~ **OR** ☒ Name of Physician/Person/Organization authorized to release information to Jeffrey H. Chester, DO

_____
Name of Physician or Medical Organization

_____
Street Address

_____
City / State / Zip Code

_____
Phone Number Fax Number

To release the following medical records / information:

THREE (3) MOST RECENT OFFICE VISIT NOTES; Diagnostic reports and Lab results from one year

Release information to: Dr. Jeffrey H. Chester, DO___ **Please fax records if less than 20 pages.**

Address: 1063 Lower Main St, Ste C212 **Please mail records if more than 20 pages.**

City/State/Zip: Wailuku, Hawaii 96793-6006_

Phone / Fax: 808.249.8887 / 808.249.8889_

Release of information is for the purpose of (*check one*): ☒ Continued care ❑ Other: _____

Check one: ❑ I consent… ❑ I do not consent…
…to the release of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) for Dr. Chester to review.

1) This consent shall be valid for six (6) months from the date of the signing, unless revoked.
2) My permission is extended only for the purpose stated on this authorization.
3) If applicable, I understand that I will be responsible for any charges incurred for this service._____
initial

_____ _____
Signature of Patient or Patient's Guardian Today's Date

_____ _____
Mailing Address Phone Number

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INSTRUCTIONS: Complete this form if you have ANY type of MEDICARE insurance (examples: Medicare A/B, Humana, UnitedHealthcare, HMSA 65C+, HMSA Senior Advantage, Kaiser Senior Advantage, Wellcare 'Ohana, AARP Medicare)

Medicare Private Contract Form

This agreement is between Dr. Jeffrey H. Chester, DO ("Physician"), whose principal place of business is 1063 Lower Main Street, Suite C212, Wailuku, Hawaii 96793, and patient (print name)_____ ("Patient"), who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician opted out of the Medicare program effective January 01, 2013, and continues to opt out of Medicare programs, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"): Consultation appointment, Re-evaluation appointment, Osteopathic Manual Therapy, Injection, and/or Electrodiagnostic Medicine/Nerve Conduction Study.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Selfpay Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges they have a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to them.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or their beneficiaries.

Executed on [Date] _____ between Dr. Jeffrey H. Chester, DO and

[Patient name] _____

[Patient signature] _____

[Physician signature] _____

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INSTRUCTIONS: Complete this form if our office does not participate with your medical insurance, or if you do not have any medical insurance.

FINANCIAL POLICY – SELFPAY/PRIVATE PAY FORM

In order to ensure the highest quality service and medical care to our patients, Dr. Chester's medical practice does not overbook or schedule walk-in appointments. This means if you do not arrive on-time for your scheduled appointment, do not show up, or cancel/reschedule without at least 24 hours' notice, there is an unplanned opening in our schedule. **For these reasons, our office requires pre-payment for your initial office visit before reserving a date and time for your appointment.**

An initial medical evaluation with Dr. Chester is $400.00, due in-full prior to scheduling the initial visit.
A follow-up medical evaluation with Dr. Chester is $232.46, due in-full prior to each follow-up visit.

By signing below, I understand that if I am accepted into Dr. Chester's medical practice, I acknowledge all of the above and I accept the charges associated with my medical evaluations with Dr. Jeffrey H. Chester.

If I am accepted into Dr. Chester's medical practice, I will call your office to find out the best day/time for me to make my pre-payment in-person with my MasterCard, VISA or Cash (no personal checks). I understand Dr. Chester's office will schedule my initial appointment once my payment is successfully processed.

Once your non-refundable pre-payment is successfully processed, you will have an appointment scheduled for a medical evaluation with Dr. Chester. Please note that if you do not show up for your appointment, are more than 15-minutes late, or do not re-schedule with at least 24 hours' notice, a $100 fee will be assessed to your account which must be re-paid prior to re-scheduling your appointment. A copy of this completed document will be provided to you at your initial office visit and become a written receipt for your records..

Print your full name: _____

✍ _____
Your signature acknowledging all of the above Date

Below To Be Completed By Dr. Chester's Office: _____

❑ Date payment processed:_____ Processed by:_____

❑ Copy to Patient

Appointment scheduled for:_____ at _____am / pm

Form effective 02/26/2024