



PATIENT INFORMATION

(Please Print Clearly)

Patient Name (Full): _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Birth Date: _____

Cell Phone: _____ Other Phone: _____ Email: _____

Gender: Male Female Marital Status: Single Married Widowed Divorced Separated

Social Security #: _____ Occupation: _____

Referring M.D.: _____ Primary Care M.D.: _____

Emergency Contact/relationship to you: _____ Phone: _____

Are you seeking treatment for a condition related to a work or auto injury? Yes No

FINANCIALLY RESPONSIBLE PERSON Self

Insured: _____ Relationship to you: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Birth Date: _____

MEDICAL INSURANCE COVERAGE See Card No Insurance (will pay at time of service)

Primary Insurance Company and Billing Address: _____

ID/Policy #: _____ Group #/Name: _____ Subscriber: _____

Secondary Insurance Company and Billing Address: _____

ID/Policy #: _____ Group #/Name: _____ Subscriber: _____

Workman's Comp. or No Fault Insurance Company and Billing Address: _____

ID/Policy #: _____ Group #/Name: _____ Subscriber: _____

Employer: _____ Claim #: _____ Date of Injury: _____

Claims Adjuster: _____ Phone: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION: *(Please read and sign)*

I hereby authorize payment of medical benefits to BAINBRIDGE ISLAND PHYSICAL THERAPY, LLC for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing. *I certify that the information I provide is true and correct to the best of my knowledge. I give permission to the practitioner to administer and perform such procedures as may be deemed necessary for treatment.*

Patient Signature: _____ Date: _____

For persons under age 18-Parent signature: _____ Date: _____



HEALTH HISTORY FORM

Please speak directly with your Physical Therapist if you have any medical history issues that you wish not to list.

Name: _____ Age: _____ Date _____

Date of last complete medical examination: _____ Performed by: _____

List your chief complaint as well as any other health problems that you would like addressed: _____

Please list the prescription medications which you are presently taking or have recently stopped taking:

Please list the over the counter medications which you are presently taking or have recently stopped taking:

Allergies: None Medications Food Environmental Other (list reaction for each)

Surgeries: _____

Relevant Imaging, X-rays, MRI, CT (specify by name, dates and results if known): _____

Exercise when injury free (list recent activities, frequency, duration, as well as future goals): _____

Besides the condition which you are here for, do you need advice on proper exercise? Yes No

At present do you consider yourself to be a healthy person? Yes No

PAST MEDICAL HISTORY

CANCER: I have not been diagnosed with, nor do I suspect that I have cancer

List type of cancer, treatments, and dates _____

INFECTION No History of Relevant Infections.

Tuberculosis Lymes Abscesses HIV/AIDS Kidney

Chronic lung Hepatitis B, C Heart valve Skin Bone

Other _____

LUNG My lungs are fine.

Asthma Pain with deep breath Lung disease Difficulty breathing or shortness of breath

Other _____

HEART I have no known heart problems.

Angina (chest pain) Valve disorder Arrhythmia (fast or slow)

Pacemaker/ Defibrillator Cardiac Hypertrophy (Enlarged Heart) Congestive heart failure

Fainting Palpitations Bypass surgery

Other _____

SMOKING: I don't smoke. I smoke or smoked _____ packs per day for _____ years.

BLOOD VESSELS I have no known circulatory problems.

- Deep Vain Thrombosis Edema Artery bypass surgery
 Calf pain with walking Raynaud's Disease Arteriosclerosis
 Other _____

GASTROINTESTINAL I have no abdominal pain or gastrointestinal complaints.

- Gall bladder stone Appendix surgery Nausea Infection Colitis
 Crohn's Disease Blood in stools Vomiting Belly pain Diarrhea
 Ulcer Change in stools Swallowing difficulty Other _____

KIDNEY My kidneys are fine.

- Kidney infection Kidney stone Pain with urination Loss of urine control
 No urination for 24 hours Other _____

RHEUMATOLOGIC I have no rheumatologic disease.

- Rheumatoid Arthritis Fibromyalgia Lupus Scleroderma
 Ankylosing Spondylitis Myofascial Pain Syndrome Undiagnosed Joint swelling or deformity
 Other _____

NEUROLOGIC I have no neurologic impairments.

- Multiple Sclerosis Seizure Nerve related weakness Neuromuscular disease
 Pain Tingling Loss of sensation Migraines Non-Migraine headaches
 Other _____

SKIN I have no skin issues.

- Open wounds Contact Dermatitis Psoriasis Hives Rash Skin Cancer
 Other _____

SPINE/ORTHOPAEDIC/BONES I have no orthopaedic issues.

- Sprain/Strain Osteoporosis Fracture Dislocation Joint pain Neck/back problems
 Swelling Motor vehicle injury Old athletic injury Old trauma Surgery _____
 Other _____

REPRODUCTIVE Not applicable. Presently pregnant Trying to become pregnant

PSYCHIATRIC Not applicable.

- Severe depression Panic attack Psychotic disorder Claustrophobia
 Other _____

GENERAL I am healthy (other than your physical therapy needs).

- Hypertension (high blood pressure) Elevated Cholesterol Chronic Fatigue Weakness
 Pain at night Weight loss or gain Hormonal disorder Diabetes - year diagnosed _____
 Weakness Other _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____



CONDITIONS OF TREATMENT

PATIENT RESPONSIBILITY: As a patient receiving medical care, you should be aware of your insurance coverage and limitations. Many insurance companies require pre-authorization for physical therapy treatments. It is my responsibility to determine insurance benefits and that Bainbridge Island Physical Therapy will assist me in obtaining the necessary pre-authorizations when needed. Failure to obtain necessary pre-authorizations may result in a reduction or rejection of benefits by the insurance company.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize my insurance company to pay Bainbridge Island Physical Therapy, LLC directly. I understand that I am responsible for charges not covered by my insurance company including late penalty charges. I agree that a photocopy of this authorization is as effective and valid as the original.

MEDICARE AUTHORIZATION; PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named below to release such information to the Social Security Administration, its intermediaries, or carriers, effective from this date to indefinite.

CONFIDENTIALITY: Your medical history and personal information will be held in strict confidence. Your case will only be discussed or shared for purposes of necessary communication with your physician or to satisfy requirements for payment from your insurance company.

POLICY ON PATIENT ACCOUNTS

PRIMARY INSURANCE: We will be happy to bill your insurance for you if you provide us with the appropriate billing information. Your insurance will make payment directly to Bainbridge Island Physical Therapy, you will be responsible for any deductible, co-payments or other patient balances. If you have a balance on your account, you will receive a monthly statement until the account is paid in full.

PAYMENT OPTIONS: Payment options include cash or check.

SECONDARY/SUPPLEMENTAL INSURANCE: We bill the majority of secondary/supplemental insurance companies. Please notify us if you wish your secondary/supplemental insurance automatically billed.

All bills are due and payable upon receipt of your monthly statement. If you have special financial needs, please discuss these with us at the time of service.

Past due accounts may be assigned to an outside agency for collection.

I have read and understand this financial agreement. I have had an opportunity to ask questions and accept the responsibility of its terms.

Patient/Responsible Party

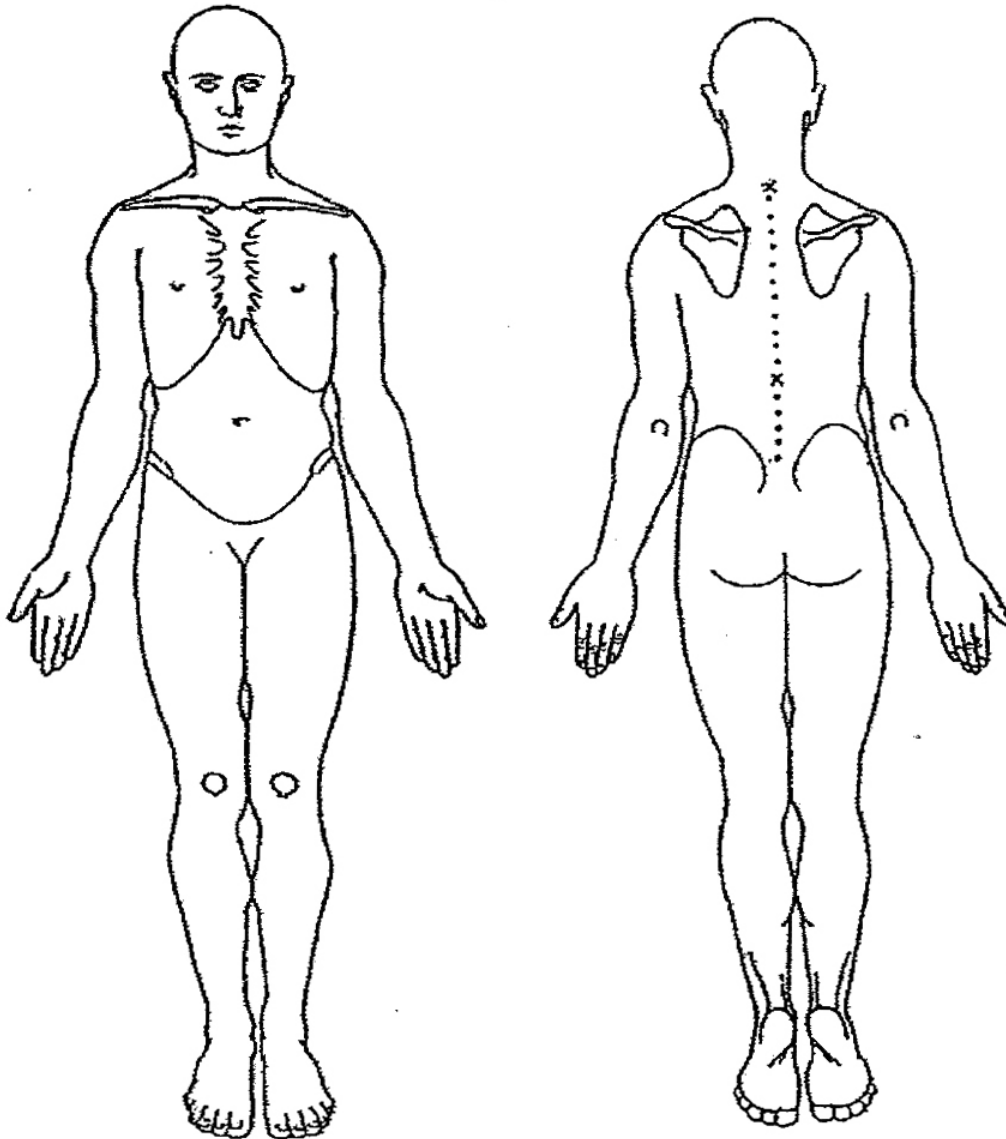
Date

Welcome to our practice and if you have any questions at any time please ask.



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Body Chart



Please indicate on the diagram where you are currently experiencing:

- | | |
|-------------|---------------------------------|
| xx Pain | ss Burning |
| // Numbness | oo Other (Please explain) _____ |
| ~ Tingling | |

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