



PATIENT INFORMATION

563 Madison Ave. N., Bainbridge Island, WA 98110 (206)855-8455

Date: _____

Name: First _____ MI _____ Last _____ DOB: _____

Biological Sex: F M Preferred Pronouns: _____ Occupation: _____

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

Phone: Home _____ Mobile _____ Work _____
(Please check where we can leave a detailed message of patient information during business hours)

Email Address: _____ SSN: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Workman's Compensation or No Fault: _____ Primary M.D.: _____
Seeking treatment for a condition related to a work or auto injury? Yes No Referring M.D.: _____

Insurance Information or Same Day Payment (\$130 per visit)

Primary Insurance: _____ Secondary Insurance: _____
Member ID#: _____ Member ID#: _____
Subscriber: _____ DOB: _____ Subscriber: _____ DOB: _____
Financially Responsible: _____ Self Relation: _____

Conditions of Treatment & Financial Policy
Please initial on the line adjacent to each policy to acknowledge you have read and understand each policy

PATIENT RESPONSIBILITY: *Initial* As a patient receiving medical care, I understand my insurance coverage and its limitations. It is my responsibility to determine my insurance benefits and to provide Bainbridge Island Physical Therapy with accurate and complete billing information. I agree to assist in obtaining any required authorizations. Failure to do so may result in a reduction or denial of insurance benefits. I am responsible for all deductibles, copayments, and any other patient balances not covered by insurance. Balances are due upon receipt of a monthly statement. Accepted payment methods include cash, check, or HSA credit card. I understand that past-due accounts may be sent to an outside collection agency and will incur an additional 40% collection fee. I have had the opportunity to ask questions and accept responsibility for these terms.

VISIT LIMITATIONS: *Initial* I understand that my insurance may limit the number of combined visits per calendar or plan year for services including Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP), Massage Therapy (MT), Chiropractic (Chiro), and Hydrotherapy. I agree to inform the staff if I have received these services elsewhere. I also understand that my insurance may limit coverage to one provider per day for these services. I am responsible for any charges not covered by my insurance.

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFO / CONSENT TO CARE: *Initial* I consent to care and authorize my insurance carrier, including Medicare, VA, Military, private, and commercial insurers, to make payment directly to Bainbridge Island Physical Therapy for services provided to me or my dependents. I authorize the release of medical information necessary to process insurance claims. Information will only be shared as necessary for communication with my physician or to meet insurance and payment requirements. I understand that I am responsible for any amounts not covered by insurance. I certify that the information I provide is true and correct to the best of my knowledge. I give permission for the practitioner to perform treatments and procedures deemed necessary for my care.

NO SHOW/CANCELLATION POLICY: *Initial* Bainbridge Island Physical Therapy reserves the right to charge a \$130 fee for scheduled appointments that are missed or canceled with less than 4-hour notice. This fee is not billable to insurance and must be paid in full to maintain future appointments.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Bainbridge Island Physical Therapy 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: _____

Are you currently receiving ANY form of Home Health Care: Yes No For? _____

Next scheduled Dr. appointment(s) Date: _____ Physician: _____

When did your condition start? Please give specific date of injury or onset of pain/symptoms: _____

Did you have surgery? Yes No Surgery Date: _____ Procedure: _____

Did you have the following tests? Xray MRI CT Scan EMG Other: _____

Have you been treated here or by another physical therapist before? Yes No Same Condition? Yes No

Where? _____ When? _____ Who referred you to BIPT? _____

Are you currently taking any medications? Yes No Please list below or bring in a medication list.

Do you have pain? If so draw on the Body Chart where your pain is located

What does your pain feel like? (check all that apply)

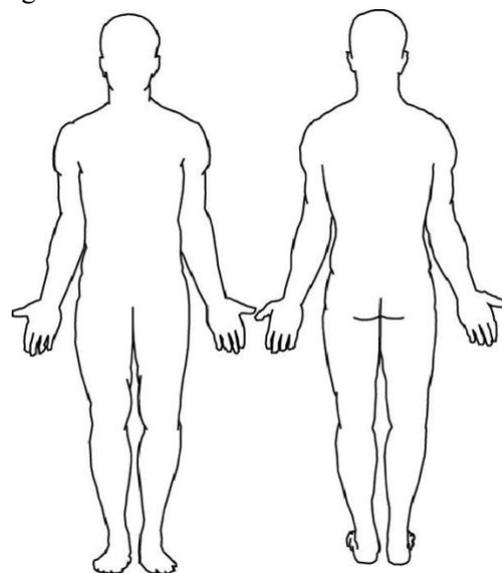
Sharp Burning Aching Tingling Numbness

Other: _____

Does your pain radiate to arms or legs? Yes No

Does your pain keep you up at night? Yes No

Rate your PAIN: _____ (0=none, 10=severe)



What makes your pain worse? (check all that apply)

Lying down Sitting Standing Walking Other _____

What eases your pain? (check all that apply)

Lying down Sitting Standing Walking Other _____

Recent weight loss or gain? Yes No Height _____ Weight _____ BMI _____

Exercise when injury free? Yes No Any other conditions we should be aware of? _____

Are you pregnant? Yes No

Were you in a Motor Vehicle Accident? Yes No

Do you now or have had any of the following? (check all that apply)

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Hernia (any) | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Previous Surgery | <input type="checkbox"/> Metal Implants |

If yes to any of the above, please give details and approximate dates: _____

All statements above are true to the best of my knowledge _____

PATIENT SIGNATURE and DATE

