PATIENT INFORMATION

BAINBRIDGE ISLAND PHYSICAL THERAPY

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:
Seeking treatment for a condition related to a work or auto injury? ☐ Yes ☐ No

Primary M.D: _____

Referring M.D.: _____

Workman's Compensation or Motor Vehicle Accident

Insurance Company: _____

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

Claim Number: _____ **Date of Injury:** _____

Claim Manager: _____ **Phone:** _____

Conditions of Treatment & Financial Policy

Please initial on the line adjacent to each policy to acknowledge you have read and understand each policy

_____ **Initial** **PATIENT RESPONSIBILITY:** 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.

_____ **Initial** **VISIT LIMITATIONS:** 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.

_____ **Initial** **ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFO / CONSENT TO CARE:** 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.

_____ **Initial** **NO SHOW/CANCELLATION POLICY:** 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: _____

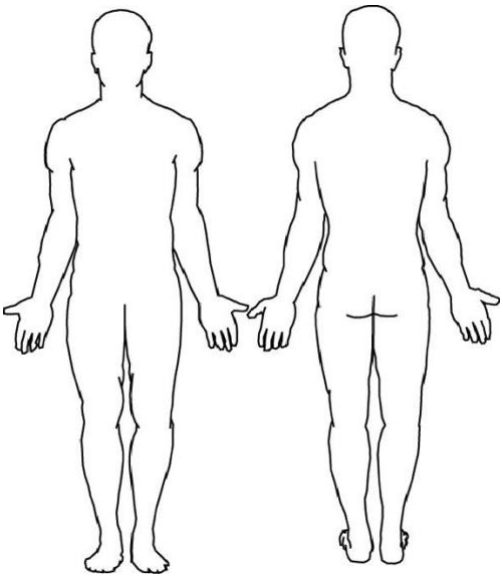
Did you have the following tests? ☐ Xray ☐ MRI ☐ CT Scan ☐ EMG Other:_____

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)

☐ Heart Disease	☐ Diabetes	☐ Allergies	☐ High Blood Pressure	☐ Asthma
☐ Heart Attack	☐ Pacemaker	☐ Kidney Problems	☐ Headaches	☐ Thyroid Issues
☐ Cancer	☐ Infectious Disease	☐ Hernia (any)	☐ Nervous Disorders	☐ Seizures
☐ Stroke	☐ Dizziness	☐ Shortness of Breath	☐ Previous Surgery	☐ 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