PATIENT INFORMATION

BAINBRIDGE ISLAND PHYSICAL THERAPY

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

Name: First_____ MI_____ Last_____ **Gender:** ◯ F ◯ M

DOB:_____ **Marital Status:** ◯ Single ◯ Married ◯ Other **Occupation:**_____

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

Phone: ☐ Home _____ ☐ Cell _____ ☐ 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.:_____

Insurance Information

Primary Insurance:_____ **Secondary Insurance:**_____

Member ID#:_____ **Member ID#:**_____

Subscriber:_____ **DOB:**_____ **Subscriber:**_____ **DOB:**_____

Financially Responsible:_____ ☐ Self **Relation:**_____

Conditions of Treatment & Financial Policy

PATIENT RESPONSIBILITY: As a patient receiving medical care, I am aware of my insurance coverage and limitations. It is my responsibility to determine insurance benefits and provide Bainbridge Island Physical Therapy with correct billing information. I will assist with obtaining necessary pre-authorizations when needed as failure to obtain this may result in a reduction or rejection of benefits by the insurance company. I will be responsible for any deductible, copayments, or other patient balances due and payable upon receipt of a monthly statement. Payment options include cash, check or HSA credit card. I understand that past due accounts may be assigned to an outside agency for collection. I have had an opportunity to ask questions and accept the responsibility of these terms.

CONFIDENTIALITY/RELEASE OF MEDICAL INFO: 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. A detailed copy of our Privacy Policy is available upon request.

ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL INFO: I hereby authorize payment of medical benefits to Bainbridge Island Physical Therapy for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process insurance claims. I understand that I am responsible for any amount not covered by insurance. I certify that the information I provide is true and correct to the best of my knowledge. I give my permission to the practitioner to administer and perform such procedures as may be deemed necessary for treatment.

NO SHOW/CANCELLATION POLICY: Bainbridge Island Physical Therapy reserves the right to charge a $45 fee for patients who do not show up to a scheduled appointment or cancel less than 4 hours in advance. This fee will not be billed to or covered by your insurance.

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: Give specific date of injury or onset of pain?_____

Did you have surgery? ◯ Yes ◯ No Surgery Date:_____Procedure:_____

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

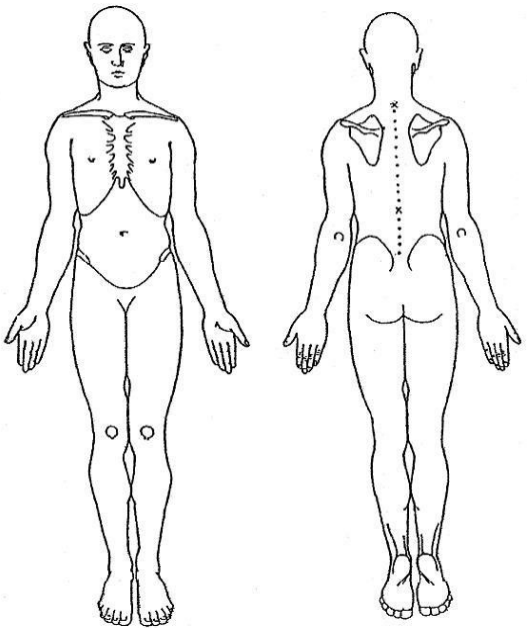
Have you been treated here or by another physical therapist before? ◯ Yes ◯ No Same condition? ◯ Yes ◯ No

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 pain radiate to arms or legs? ◯ Yes ◯ No

Does the 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 Desease	☐ 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