



PATIENT INFORMATION

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

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)

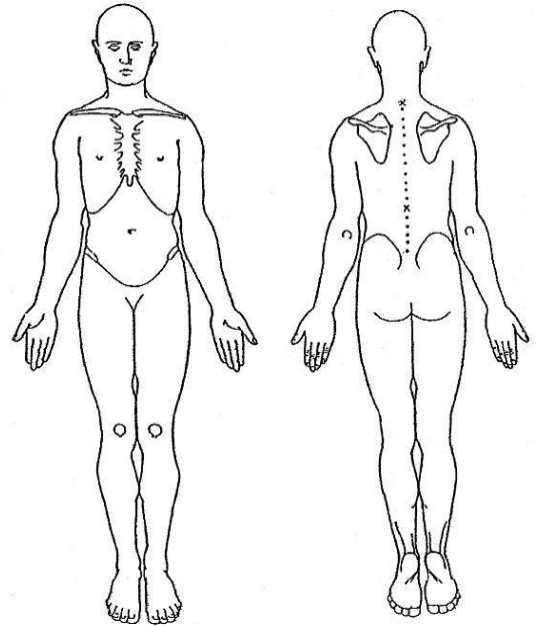
- Sharp Burning Aching Tingling Numbness

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 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

