



# 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.

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Patient/Responsible Party

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Date

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