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.: _____

Insurance Information or ☐ Same Day Payment ($125 per visit)

Primary Insurance: _____

Member ID#: _____

Subscriber: _____ **DOB:** _____

Financially Responsible: _____ ☐ Self

Secondary Insurance: _____

Member ID#: _____

Subscriber: _____ **DOB:** _____

Relation: _____

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 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.

_____ **Initial** **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.

_____ **Initial** **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.

_____ **Initial** **NO SHOW/CANCELLATION POLICY:** Bainbridge Island Physical Therapy reserves the right to charge a $125 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. This fee must be paid in full in order to maintain any future scheduled 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: _____

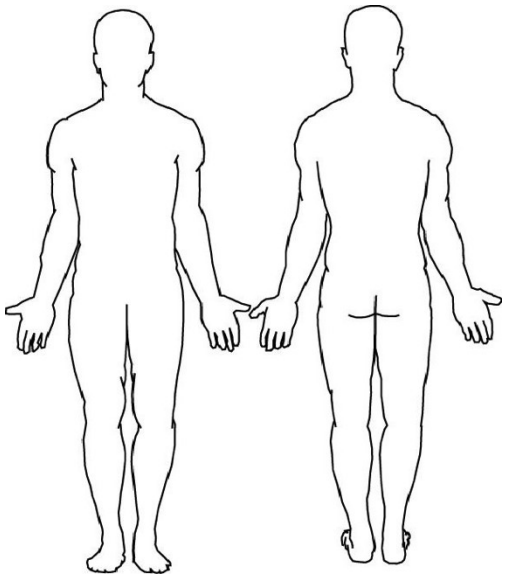
Did you have the following tests? ☐ Xray ☐ MRI ☐ CT Scan ☐ EMG Other:_____

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