PATIENT INFORMATION

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 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: ____________________

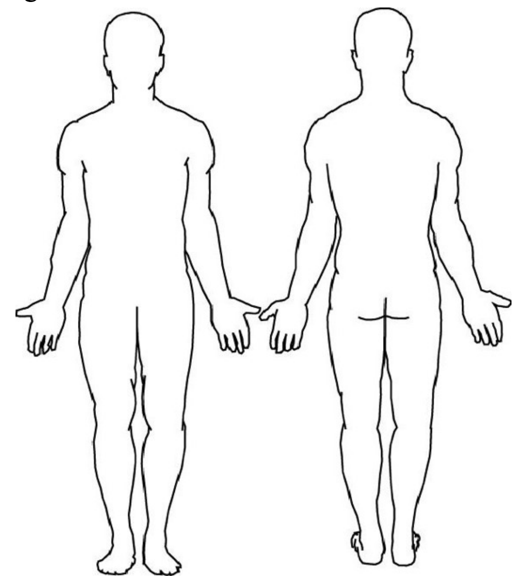
Did you have the following tests? ☐ Xray ☐ MRI ☐ CT Scan ☐ EMG Other:____________________

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