Welcome to Island Sports Physical Therapy.

Please complete this informational sheet so that we can accurately process your claims.

PATIENT INFORMATION

Patient Name: _____ DOB: _____ SS#_____

Male: _____ Female: _____ Email address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ OK to leave detailed message _____ Y _____N

Cell Phone: _____ OK to leave detailed message _____ Y _____N

Employer: _____ Occupation: _____

Primary Ins.: _____ Phone: _____ Policy#: _____

Secondary Ins. _____ Phone: _____ Policy#: _____

Referred by:

Doctor____Friend ____Relative:____Prior patient:____Internet:____Sign:____Ins:___Other:___

No Fault Information (auto related)

N/F Carrier:_____DOA: _____Claim#:_____

Adjustor Name/Phone: _____ Attorney Name/Phone: _____

Worker's Compensation (work related accident)

W/C Carrier:_____DOA: _____WCB#:_____

Carrier Case #: _____ Adjustor's name/phone: _____

Who is responsible for this account (if minor or spouse)?

Name: _____ Relationship to patient: _____

Home phone: _____ SS# _____ DOB: _____

Street Address _____ City _____ State _____ Zip _____

Name, relationship & phone # to contact in an emergency: _____

Patient Signature: _____ Date: _____

ISLANDSPORTS PHYSICAL THERAPY

PATIENT HEALTH QUESTIONNAIRE

Name _____ ___ Date _____

1. Please describe your current complaint or limitation: _____

_____

2. What is your goal for therapy: _____

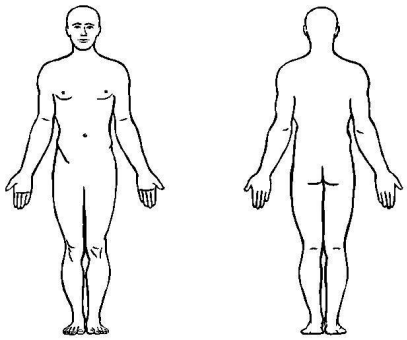
_____

a. Please describe the nature of your pain:

- O Sharp pain
- O Dull (pain) ache
- O Throbbing
- O Numbness
- O Shooting
- O Burning
- O Tingling

- O Constant (76-100%)
- O Frequent (51-75%)
- O Occasional (26-50%)
- O Intermittent (25% or less)

PLEASE CIRCLE INJURED AREA
UPON PRINTING



b. Indicate the intensity of your pain at rest: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Indicate the intensity of your pain with movement: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

c. What movement causes the pain to increase: _____

d. Since this condition began your symptoms have: O decreased O not changed O increased

e. Your symptoms are worse in: O morning O afternoon O night O increased during day O same all day

3. When did your problem begin:_____days ago / months ago / years ago specific date _____

Describe how your problem began: _____

_____

Did you have surgery? O Yes O No Date of surgery _____

4. In the past have you been treated for the same problem? O Yes O No

5. What makes your problem better? O Nothing O Lying down O Standing O Sitting O Movement/Exercise O Inactivity

6. What makes your problem worse? O Nothing O Lying down O Standing O Sitting O Movement/Exercise O Inactivity

7. Occupation _____ O F/T O P/T

Has your work status changed because of this condition O Yes O No

8. What is your current work status? O FT, no restrictions O PT, no restrictions O Retired O Unemployed
O FT, with restrictions O PT, with restrictions O Full time student
O Full time homemaker O Off work due to restrictions

9. Medications? If yes, please list _____

10. Past or Present Medical History _____

GUARANTEE AGREEMENT

I. Individual's Responsibility for Non-Covered Services:

In consideration of services rendered by Island Sports Physical Therapy, PC to the undersigned patient, the undersigned promises to pay Island Sports Physical Therapy any copayment, coinsurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided I am informed of same prior to the rendering of said services.

II. Assignment of Benefits Proceeds:

I hereby assign to Island Sports Physical Therapy PC all monies and/or benefits to which I am entitled from my insurer/HMO/third party/government agencies, or those who are financially liable for my medical care.

III. Authorization to Release Records:

I hereby authorize Island Sports Physical Therapy PC to release to my insurer/HMO/third party payer, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification & prior approval purposes.

It is, however expressly understood that there will be no obligation of the undersigned to pay for any services, other than those services covered by Paragraph I above, which are not Medically Necessary or improperly billed.

IV: Patient is responsible for collection fees, court fees, and reasonable attorney fees to collect unpaid accounts.

V. Patient is responsible to obtain, and bring with them, a referral from their primary care physician if a referral is required by their insurance plan.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Signature of Island Sports PT representative Date

PERSONAL REPRESENTATIVE FORM

I_____ appoint the following person(s) as my personal representative(s).

_____

_____

_____

The above named person(s) has (have) my permission to obtain any Private Health Care Information from Island Sports Physical Therapy regarding my care as well as any billing information in conjunction with the above mentioned care.

_____ _____

Signature Date