



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: _____



PATIENT HEALTH QUESTIONNAIRE

Name _____

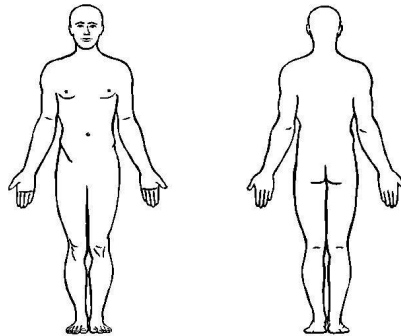
Date _____

1. Please describe your current complaint or limitation: _____

2. What is your goal for therapy: _____

a. Please describe the nature of your pain:

- | | |
|--|--|
| <input type="radio"/> Sharp pain | <input type="radio"/> Constant (76-100%) |
| <input type="radio"/> Dull (pain) ache | <input type="radio"/> Frequent (51-75%) |
| <input type="radio"/> Throbbing | <input type="radio"/> Occasional (26-50%) |
| <input type="radio"/> Numbness | <input type="radio"/> Intermittent (25% or less) |
| <input type="radio"/> Shooting | |
| <input type="radio"/> Burning | |
| <input type="radio"/> Tingling | |



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: decreased not changed increased

e. Your symptoms are worse in: morning afternoon night increased during day 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? Yes No Date of surgery _____

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

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

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

7. Occupation _____ F/T P/T

Has your work status changed because of this condition Yes No

8. What is your current work status? FT, no restrictions PT, no restrictions Retired Unemployed

FT, with restrictions PT, with restrictions Full time student

Full time homemaker Off work due to restrictions

9. Medications? If yes, please list _____

10. Past or Present Medical History _____



ISLANDSPORTS®
PHYSICAL THERAPY

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