Tru
Physical Therapy

70 E. Horizon Ridge Pkwy #180
Henderson, NV 89002
P: 702-856-0422 F: 702-433-0425
truphysicaltherapy2018@gmail.com

Notice of Privacy Practices, Consent, and Assignment of Benefits

This notice describes how your medical information may be used, disclosed, and accessed. Please review it carefully.

Uses and Disclosures of Health Information:
We use your health information for treatment, payment, administrative purposes, and quality care evaluation. Continuity of care is part of your treatment, and we may share your records with other providers involved in your care. Certain uses or disclosures may occur without your authorization, but otherwise, we will seek your written consent before using or disclosing any identifiable health information about you.

Your Rights:
You have the right to view or obtain a copy of your health information, though nominal fees may apply for copies. You may request a list of certain disclosures of your information, and you can request corrections if you believe information in your record is incorrect. Tru Physical Therapy complies with Federal civil rights law and does not discriminate in any way, shape, or form.

Our Legal Duty:
We are legally required to protect the privacy of your information, to provide notice of our information practices, to follow the practices outlined here, and to seek your acknowledgment of this notice. If we make significant policy changes, we will update this notice and make it available in our waiting area. You may request a copy at any time. For questions, please contact management.

Complaints:
If you believe your privacy rights have been violated or disagree with a decision about access to your records, you may contact management or file a complaint with the U.S. Department of Health and Human Services.

Waiver of Liability:
I understand that physical therapy may involve risks and that Tru Physical Therapy is not liable for injuries that occur on the premises, whether to the patient or a guest, including any use of equipment. I acknowledge that no oral agreement will substitute for this signed document.

Billing and Financial Responsibility:
Any charges will be billed to the insurance information provided, with the patient accepting responsibility for deductibles, co-insurances, and copays. I understand that my insurance, including Medicare, may review the medical necessity of my physical therapy, and if denied, I may be responsible for those charges. A valid doctor's referral must be on file throughout my treatment. If insurance denies payment, I agree to work with Tru Physical Therapy to resolve the matter.

Assignment of Benefits and Authorization to Release Information:
I authorize my insurance company to make payments directly to Tru Physical Therapy for covered services provided to me. I understand that this assignment of benefits does not relieve me of my financial responsibility for services rendered. I also authorize Tru Physical Therapy to release any necessary information about my treatment to my insurance or other relevant third parties to process claims or coordinate benefits, including diagnosis, treatment, and billing information.

Notice of Benefits:
I have reviewed and fully understand my insurance benefits.

Consent for Treatment:
By signing below, I give full consent for Tru Physical Therapy to treat my injuries in accordance with Nevada State law, including the Nevada Physical Therapy Practice Act.

Initials_____

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Patient Name:_____ Date of Birth:_____

SSN:_____ (Required for workers' comp patients)

Address:_____City:_____ State:_____ Zip: _____

E-Mail: _____ Phone: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Employer: _____ Phone: _____

Employer Address:_____

Are you the primary insurance policyholder? □ Yes □ No

If no, please provide the policyholder's name and date of birth: _____

Are you receiving home health care of any kind?. □ Yes □ No

History and Physical Condition Information

Answers to the following questions will assist the therapist in providing the most effective treatment program.

Name: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

Problem we are seeing you for: _____ How long have you had this problem: _____

Referral source (Other than Physician) : □ Family/Friend □ Website □ Google □ Facebook □ Yelp

□ Other: _____

Have you had other treatments for this problem: _____

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Have you had surgery for this problem? □ Yes □ No If yes, Date of Surgery: _____

Please list current medications if you have not provided a list: _____

_____

Please list other illnesses or surgeries that you have had in the past year: _____

_____

Do you have any of the following conditions (please circle):

High Blood Pressure	Cancer	Headaches
Heart Disease	Metal Implants	Dizziness
Heart Attack	Vision Issues	Vestibular Disorders
Pacemaker	Seizures	Falls
Diabetes	Neurological Disorders	Pregnancy
Kidney Disease	Balance Issues	Hearing Issues

Are you currently pregnant: □ Yes □ No

Are you currently experiencing fever, cough, fatigue or other potential COVID symptoms: _____

I understand, fully consent, and agree to the information provided to me on this and the previous page.

Signature

Printed Name: _____

Signature: _____ Date: _____

(parent or legal guardian if under 18)

If there are any questions or concerns, please feel free to contact management at the above contact information.

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24 Hour Cancellation Policy

We understand that emergencies and scheduling conflicts sometimes arise and are unavoidable. However, providing advance notice allows us to accommodate other patients' needs and keep the clinic running efficiently. Due to our clinician-to-patient ratio, missed appointments are a significant inconvenience to the clinic and to other patients.

This policy is in place out of respect for our clients and your physical therapist. Cancellations with less than 24-hour notice are difficult to fill, preventing other patients from scheduling into that time slot and creating gaps in your therapist's schedule.

- Please provide our office with 24-hour notice to change or cancel an appointment.
- Patients who do not attend a scheduled appointment or who cancel without 24-hour notice may incur a **$25.00 SERVICE CHARGE**. This charge **cannot be billed to insurance** and must be paid on or before the next scheduled appointment.
- **Important:** Certain insurance or accident claims adjusters expect consistent attendance to physical therapy as part of the approved treatment plan. Missing or frequently canceling appointments may affect the status of your claim. Your treatment plan has been established by your medical practitioner(s) to help you return to your regular activities quickly and safely. Missing appointments hinders that process and may end up prolonging your recovery.
- You may reschedule your appointment to a different day within the same week to avoid the service charge. However, **an existing appointment does not count as a reschedule**. To qualify, a reschedule must occur within the same week. For example, if you are originally scheduled for 2 visits in a given week, you must attend at least 2 visits within that week to avoid a fee.
- After several **missed** or **canceled** appointments without the required 24-hour notice, you may, at your physical therapist's discretion, be placed on a same-day scheduling policy for your treatments, which would prevent you from scheduling appointments in advance.

NOTE: You will not be charged for a cancellation if it is made more than 24 hours before your scheduled appointment. It is the patient's responsibility to keep track of appointment times. If you need a reminder, we are happy to print one upon request.

I have read, understand, and agree to abide by the policy above:

Signature

Printed Name: _____

Signature: _____ Date: _____

(parent or legal guardian if under 18)

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HIPAA Authorization for Release of Protected Health Information

Patient Information

Name: _____ Date of Birth: _____ **I authorize Tru**

Physical Therapy to release my health information to the following individual(s):

(Please list any doctors, lawyers, family members, caretakers, or anyone else you would like us to communicate with or release information to. Initial next to individuals you approve of.)

1. Name: _____Relationship: _____
   Phone: _____ Email: _____
   □ All records □ Billing □ Appointments □ Progress Notes □ Other: _____
   Purpose: □ Coordination of care □ Legal □ Insurance □ Personal □ Other:_____

2. Name: _____Relationship: _____
   Phone: _____ Email: _____
   □ All records □ Billing □ Appointments □ Progress Notes □ Other: _____
   Purpose: □ Coordination of care □ Legal □ Insurance □ Personal □ Other:_____

3. Name: _____Relationship: _____
   Phone: _____ Email/Fax: _____
   □ All records □ Billing □ Appointments □ Progress Notes □ Other: _____
   Purpose: □ Coordination of care □ Legal □ Insurance □ Personal □ Other:_____

Expiration and Revocation

This authorization will expire (please check one):
□ On (date or event): _____
□ When I revoke this authorization in writing
□ One year from the date signed

I understand that I may revoke this authorization at any time by providing written notice to Tru Physical Therapy. Revoking this authorization will not affect any information already released based on this authorization before the revocation was received. Once my information is released, it may no longer be protected by federal privacy laws.

Signature

Printed Name: _____

Signature: _____ Date: _____

(parent or legal guardian if under 18)