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

Tru
Physical Therapy

This is your provider notice of privacy practices. This notice describes how medical information about you may be used and disclosed and how you can access it. Please review it carefully.

Uses and Disclosures: We use health information for your treatment, to obtain payment for your treatment, administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of your treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of your health information. If you request copies, we may charge you nominal copy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to correct the existing information. TRU physical therapy complies with Federal civil rights law and does not discriminate in any way, shape, or form.

Our legal duty: We are required by law to protect the privacy of your information, provide notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For information regarding our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact management. You may also send a written complaint to the US Dept of Health and Human Services.

Waiver: I understand that physical therapy can be considered dangerous, unless under the supervision of staff. TRU physical therapy holds no responsibility financially or otherwise, if the patient or guest of the patient undergoes injury while on the premises, including any and all equipment. I understand that this document must be signed and no oral agreement will be accepted.

Consent: I understand that by signing this form, I give full consent for TRU physical therapy to treat any and all injuries within Nevada State law, including the Nevada Physical Therapy Practice Act.

Billing: I understand that any charges will be billed to medical insurance if the information is provided and provided correctly. I fully accept responsibility for these charges. This includes deductibles, co-insurances, co-pays, etc. If, for any reason, the insurance denies charges, I understand that TRU physical therapy will work to provide an outlet for financial resolution.

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

Authorization for Release of Information: I hereby authorize the use or disclosure of my individually identifiable health information. I understand that this is voluntary. I understand that if the organization or individual listed below is not a health plan or provider, my information may not be protected by federal privacy regulations. I give the individuals listed on the next page permission to receive copies of my information.

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Patient Name:_____ Date of Birth:_____Social:_____

Address:_____City:_____ State:_____ Zip: _____

E-Mail: _____ Phone: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Employer: _____

I authorize the following people access to my medical information:

Name:_____ Relationship:_____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

I am not currently receiving home care therapy of any kind.

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

Name:_____ Date: _____

Signature: _____

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

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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: _____

Were you referred to us by someone other than your doctor: (Family/Friend, Website, Google, Facebook, Yelp, Other): _____

Have you had other treatments for this problem: _____

Have you had a surgery for this problem: _____ When was your 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	Seizures
Heart Disease	Neurological Disorders
Heart Attack	Balance Issues
Pacemaker	Headaches
Diabetes	Dizziness
Kidney Disease	Vestibular Disorders
Cancer	Falls
Metal Implants	Pregnancy
Vision Issues	Hearing Issues

Are you currently pregnant: _____

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

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24 Hour Cancellation Policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notice allows us to fulfill other patient's schedule needs and keeps the clinic operating at its most efficient level. Due to our clinician to patient ratio, missed appointments are a significant inconvenience to the clinic and 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. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot and leave a hole in your therapist's schedule.

1. Please provide our office with 24-hour notice to change OR cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a **$25.00 SERVICE CHARGE.** This charge cannot be billed to your insurance and must be paid on or before your next scheduled appointment.
2. Certain accident claims adjusters expect regular attendance to physical therapy as a requirement for approved treatment plan. If appointments are missed or canceled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioner (s) to get you back to your regular activities and quickly and safely as possible. Missing appointments hinders that process and may end up prolonging recovery.
3. After TWO MISSED or CANCELED appointments without the proper 24-hour notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

NOTE: you will never be charged for a cancellation if it is made more than 24-hours in advance of your scheduled appointment time. Patients are responsible for knowing their scheduled appointment times. If you need a reminder, one can be printed for you upon your request. Thank you for providing our office and our patients with this courtesy.

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

Print Name:_____

Signature:_____Date:_____