PROVIDER NOTICE
OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Key Issues

Uses and Disclosures: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of 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 health information about you. If you request copies, we may charge you only normal photocopy 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 request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this 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 more information about 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 the person listed below. You also may send a written complaint to the U. S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions, comments, or complaints, please contact:

Owner: Christopher Evans

Office/ Billing Manager: Kassidi Smith

70 E. Horizon Ridge Pkwy #180
Henderson, NV 89002

Phone: (702) 856-0422 Fax: (702) 433-0425

Tru physical therapy

70 E. Horizon Ridge Pkwy #180
Henderson, NV 89002

Patient Name:_____ Date of Birth: ___/__/___ Social Security:_____-_____-_____

Address:_____ Apt. #:_____ City:_____

State:_____ Zip Code:_____ Phone Number:_____

E-mail Address:_____

Employer Information:

Employer:_____
Address:_____ Suite #:_____ City:_____
State:_____ Zip Code:_____ Phone Number:_____

Insurance Information: ****If you are the policy holder, then skip this section****

Insurance Carrier:_____
Policy Holder:_____ Date of Birth:_____
Social Security:_____ Relationship to Insured:_____

Secondary Insurance:

Insurance Carrier:_____
Policy Holder:_____ Date of Birth:_____
Social Security:_____ Relationship to Insured:_____

Emergency Contact:

Name:_____ Relationship:_____
Phone Number:_____ Other Contact Information:_____

*It is understood by both the patient and Tru Physical Therapy that any charges will be billed to medical insurance if the information is provided. If for any reason, the insurance denies charges (due to deductibles, coinsurances, or termination of coverage) then Tru Physical Therapy will be willing to work with the patient to provide any financial arrangements feasible. The patient is fully responsible for any payments that are made directly to the patient from the insurance company, and any coinsurances or deductibles as stated by the insurance company, including copays if not made at the time of service.

Patient Name:_____ Patient Signature_____ Date:_____

*It is understood that physical therapy can be considered dangerous, unless under the supervision of a staff member. Tru Physical Therapy holds no responsibility if the patient, friend of the patient, or family member seeks injury while on the premises of Tru Physical Therapy. Tru Physical Therapy is not financially responsible for any injuries that occur on the premises or on its equipment. It is understood that this document must be signed, no oral agreement can be arranged. Upon signing this portion, the patient also gives full consent for Tru Physical Therapy to treat any and all injuries associated with this patient.

Patient Name:_____ Patient Signature:_____ Date:_____

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Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations. I give the following individuals permission to receive copies and/or information about my medical history:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that my healthcare and the payment for my healthcare will not be affected by me signing this form. I understand that I may see and receive a copy of the information described on this form if I ask for it, and that I may also have a copy of this form after I sign it. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

Patient Name: _____ Date: _____

Patient Signature: _____

Tru
physical therapy

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HISTORY AND PHYSICAL CONDITION INFORMATION

Answers to the following questions will assist the therapist in providing a safe and effective treatment program.

Name: _____
Age: _____ DOB: _____

Referred by:
□Physician □Insurance Company
□ Friend □ Other

Referring Physician or Primary Care Physician: _____

Physician Phone Number:_____

Problem to be treated: _____

Have you had treatment for this problem before?
□ YES □ NO

If YES, state when: _____

Where did you receive treatment: _____

Have you had surgery associated with this problem?
□ YES □ NO

If YES, state when: _____

Are you currently taking any medications?
□ YES □ NO

If YES, please list all medications?

_____
_____
_____

List any other major illness, or surgery that has occurred in the past one year:

_____
_____
_____

Do you now have/or have you ever had any of the following:
□ High Blood Pressure
□ Heart Disease
□ Heart Attack
□ Pacemaker
□ Diabetes
□ Kidney Problems
□ Lung Disease
□ Cancer
□ Seizures
□ Neurological Disorders
□ Balance Problems
□ Frequent Falls
□ Sensitivity to Heat/Ice
□ Headaches
□ Dizzy Spells
□ Allergies
□ Hernia
□ Metal Implants
□ Vision Problems
□ Hearing Problems

Have you ever had physical therapy before?
□ YES □ NO

Are you pregnant?
□ YES □ NO

The above information is correct to the best of my knowledge.

Signature: _____ Date: _____