true
PHYSIOTHERAPY

3005 Skyline Blvd., Ste 140
Reno, NV 89509
p: 775.234.8226
f: 775.542.9834

NEW CLIENT / PATIENT INFORMATION

Name:		Age:	Date of Birth:
Phone Numbers: Primary:	Secondary:	E-mail*:	
Home Address:		City:	State & Zip:
Occupation & Employer Name:		Work Phone:	
Emergency Contact Name & Relationship:		Phone:	
Do you plan to submit receipts to your health insurance or flexible spending account?		Yes: _____	No: _____
Do you have a referral from your physician for treatment?		Yes: _____	No: _____
How did you find out about True Physiotherapy?			

**your email address is used for communication and notifications about relevant services or workshops and will not be shared with any other parties*

HEALTH HISTORY

Check and/or list all medical conditions you currently have or have had in the past:

_____ Cancer
_____ Pacemaker
_____ High blood pressure
_____ Diabetes
_____ Heart disease
_____ Glaucoma
_____ Gastric reflux
_____ Visual disturbance
_____ Difficulty swallowing
_____ Other:

_____Osteoporosis/Osteopenia (low bone density)
_____ Osteo-arthritis (degenerative joints)
_____ Rheumatoid arthritis
_____ Spinal stenosis or spondylolisthesis
_____ Pelvic instability or SI joint problems
_____ Radiating pain down arm or leg
_____ Paralysis
_____ Vertigo or dizziness
_____ Bowel or bladder dysfunction/numbness

_____ Currently pregnant
_____ Postpartum (<1 yr)
_____ Currently breastfeeding
_____ Headaches
_____ Fractures
_____ Neurologic disease
_____ Herniated disc
_____ Fainting spells
_____ Trouble speaking

Please list any surgeries and accidents with physical impact or trauma:

Please list medications and/or alternative remedies/treatments you are currently taking:

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CURRENT PHYSICAL CONDITION

What brings you here and what are your goals?

Do you have pain or a physical condition that is currently limiting you? Yes No
If yes, when did this problem *first* begin?

Are you currently under the care of a physician for this problem? Yes (name): _____ No

Did you have a surgery for this problem? Yes No

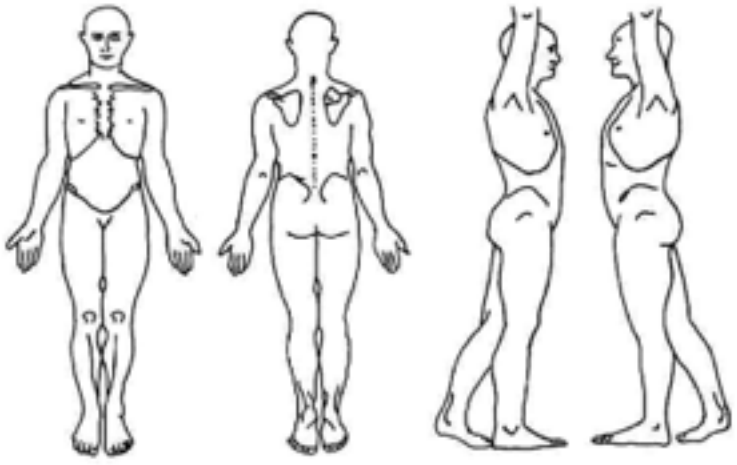
Do you have any numbness or tingling? Yes No

Do you have pain with coughing or sneezing? Yes No

How would you best describe your pain? Mild Moderate Severe

Is anything about your pain or dysfunction worrying you?

Please indicate on the chart where you have pain and/or symptoms



Patient name: _____ **Signature:** _____ **Date:** _____

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Informed Consent and Waiver & Release of Liability

I have volunteered to participate in a program of health care or fitness including physical therapy, and to retain the services of True Physiotherapy, LLC and it's employees, independent contractors and/or any future employees and independent contractors. I intend to assume all risk of injury from my participation. To that end, I acknowledge and agree to all of the following:

The treatment may include but is not limited to one or more of the following: evaluation, manual therapy, joint mobilization and manipulation, soft tissue mobilization, therapeutic exercise, neuromuscular re-education, therapeutic activities and biofeedback modalities. There are inherent risks involved in any evaluation and treatment program. It is not possible to guarantee or give assurance of a successful result. It is important that you understand and agree to the planned treatment. Physical therapy and exercise are generally safe and helpful. However, medical procedures of any type involve a risk ranging from mild to serious. It is important to be aware of the following risks before you engage in physical therapy treatment or fitness training. The likely benefits of this treatment include: improving cardiovascular fitness, muscle strength, endurance, flexibility, body posture, biomechanics, alignment, joint mobility, functional abilities and decrease or eliminate pain. During treatment and with use of the exercise equipment, the reaction of the cardiorespiratory and musculoskeletal systems cannot be predicted with complete accuracy, although our practitioners perform a thorough health screening to minimize the potential for adverse reactions. Possible reactions might include injury to the neuromusculoskeletal systems, abnormalities in blood pressure and heart rate with the rare possibility of stroke, heart attack, permanent injury and death. While particular rules, equipment and personal discipline may reduce this risk, the risk of serious injury does exist. I assume all of the foregoing risks and accept personal responsibility for any other damages or injury I might suffer. I am satisfied with my understanding of these risks. We, at True Physiotherapy, LLC, are professionally licensed by The Federation of State Boards of Physical Therapy, and the Nevada State Board of Physical Therapy Examiners. I understand that I am responsible for informing True Physiotherapy staff of any known physical limitations, illnesses or other physical conditions. Should any unusual symptoms occur during my time at the True Physiotherapy facilities, I will inform a staff member immediately. In addition, if I experience a change in my physical limitations, illnesses or other physical conditions or become ill outside the True Physiotherapy facility, I will inform staff of this change prior to resuming treatment and/or workouts on my next visit and/or contact my doctor if symptoms warrant. I have consulted my physician before participation in these programs and hereby represent to True Physiotherapy, LLC that I have their approval to engage in such activities. True Physiotherapy, LLC is a teaching facility, and, on occasion, there may be students observing patient/client sessions as it pertains to their educational requirements. There may also be interns and apprentice teachers assisting under the direct supervision of a qualified practitioner. I willingly agree to comply with the stated and customary terms and conditions for participation. If, however, I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such attention to the nearest True Physiotherapy staff member immediately.

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless True Physiotherapy, LLC, their officers, officials, agents, independent contractors, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("Releasees"), with respect to all and any injury, disability, death, or loss or damage to person or property, whether arising from the negligence of the Releasees or otherwise, to the fullest extent permitted by law. I understand that I have the right to refuse communication via email, because communications via email over the internet may not be secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

I HAVE READ THIS INFORMED CONSENT AND WAIVER & RELEASE OF LIABILITY AND FULLY UNDERSTAND ITS TERMS. I AM SIGNING THIS VOLUNTARILY AND I AGREE TO BE BOUND BY ITS PROVISIONS. I UNDERSTAND I MAY HAVE A COPY FOR MY RECORDS AT MY DISCRETION.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

FOR PARENTS/GUARDIANS OF PARTICIPANTS OF MINORITY AGE (UNDER 18 AT TIME OF REGISTRATION) This is to certify that, I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release, as provided above, of all the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, even if arising from their negligence, to the fullest extent permitted by law.

PRINT PARENT/GUARDIAN NAME: _____ SIGNATURE: _____ DATE: _____

EMERGENCY PHONE: _____ RELATIONSHIP: _____

Cancellation Policy

We take pride in the high-level quality of our services and operate differently than traditional physical therapy clinics. In order to provide you with the best possible experience, please understand the following policies and sign below in acknowledgement.

- Payment for services is due at the time services are rendered. We accept cash, check or credit card.
- Returned checks will be subject to a $35 fee, collection fees and interest charges of 3% per month.
- Cancellations of less than 24-hours advance notice or no-show will be charged the full visit rate. Exceptions under certain circumstances will be considered.

Please call as soon as you know you should not come to your appointment. Keeping clients, staff and family members healthy and safe is a priority.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

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Notice of Privacy Practices Acknowledgement

I acknowledge that I have been given a copy of or an opportunity to read the practice's Notice of Privacy Practices.

_____ _____
Patient's or Guardian's Signature Date

Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐I do not consent to any voicemail, email or texting communication.
- ☐I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) by the following means: (check all to which you consent)
  - ☐Email
  - ☐Text
  - ☐Voicemail
- ☐I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all to which you consent)
  - ☐Email
  - ☐Text
  - ☐Voicemail

E-mail address: _____

Phone number: _____

Patient Signature: _____ Date_____

Parent/Guardian Signature: _____ Date_____

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Payment Agreement

Thank you for choosing True Physiotherapy, LLC as your physical therapy and/or fitness provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

- Payment is expected at time of service unless you have made other payment arrangements with us.

- **Out-of-Network Policy**. (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.

- **Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are not enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide and the fitness services we offer are not covered by Medicare. Since we are not enrolled providers, we cannot submit claims to Medicare and Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. Therefore, by choosing our services, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - **Medicare Advantage Plans and Medicare Replacement Plans**. We are not in-network with any Medicare Advantage or Replacement Plans. If your Medicare Advantage or Replacement Plan offers out-of-network benefits for services received from providers not enrolled with Medicare and we don't have to directly submit your claims, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, you should be prepared that your health plan may not pay for services by providers not enrolled with Medicare. You are responsible for contacting your health plan to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
    - **Medicare as a Secondary Payer**. If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.

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- **Wellness & Fitness Services**. Most commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.

- **Use of Health Savings Accounts (HSA), Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** If you have an HSA, HRA or FSA account and would like to use these to pay for services using these accounts, please check with your account provider to make sure that our services are in accordance with your plan rules. You are responsible for complying with your plan rules when determining whether the services you purchase from us can be paid from an HSA, HRA or FSA account. Upon request, we will provide you a receipt for visits to justify and/or seek reimbursement for services.

- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by True Physiotherapy, LLC and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting True Physiotherapy and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

X _____ Date: _____
Signature of Patient and/or Guardian

X_____ Date: _____
Signature of Provider Representative
A photocopy of this agreement is to be considered valid, the same as if it was the original.

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ C V V: _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize True Physiotherapy, LLC to charge my credit card above for purchases agreed upon. I understand that my information will be saved on file for future transactions on my account.

_____ _____
Customer Signature Date