Schedule appointments:
(702) 665-4054

Welcome to our office where the patient's interest is the only interest. We look forward to providing you with world class service at PRISM. We continue to strive to provide comprehensive care of the whole person and total body well-being with compassion, commitment, consideration, control, and consistency throughout your care. Our highly trained staff will work on your behalf to elevate your current health status.

Physical therapy services offered at PRISM could include, but are not limited to, evaluation techniques, soft tissue techniques, manual therapy techniques, hot and cold treatments, electrical stimulation, Miracle Wave, dry needling, blood flow restrictions, Stretch-to-Win, strengthening exercises, and home exercise programs.

I have been informed that if any soft tissue techniques, particularly TPM, active release, cross frictions, are used it may leave slight bruising and tenderness in the region treated. If this technique is too uncomfortable during the treatment please advise your physical therapist so that this procedure can be modified.

I consent to rendering of physical therapy care at PRISM. I also understand that I have the right to refuse any physical therapy services offered if I so choose. I understand that physical therapy may involve some risks and I hereby release PRISM from liability now and in the future.

Financial Agreement:
I, the undersigned, agree to be responsible for all invoices related to my care. I understand it is a cash-based practice and I understand this. I also agree I will pay $25 for any returned checks. Credit card payments: By signing this form, you authorize PRISM and its affiliates to keep your credit card on file for future payments. You have the option to decline this convenience and physically produce your card at every visit. If you decline this option, please initial here.

Cancellation/no-show policy:
Any missed appointments represent a cost to PRISM, to you, and unfortunately to other patients and athletes. It is imperative that you schedule appropriately and attend your scheduled appointments on an on-time basis. Cancellations are required 24 hours prior to your appointment time. We reserve the right to charge for missed or late canceled appointments. Excessive cancellations/ no-shows may result in discharge for the practice. If you need to cancel or reschedule appointments, please feel free to call us at any time (702) 665-4054 and leave a message. By signing below, you agree to pay $100 for all physical therapy appointments that are not canceled within that 24-hour period for scheduled treatment session.

Notice of privacy in practice:
Our notice of privacy practice provides information how we may use this disclosed medical information about you. As indicated, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing, below, you are stating that you reviewed the notice of policies and practices. You may request a written copy of this document at any time. You may also any questions about this document at any time.

PERSONAL INFORMATION
Name: ______________________________ Date: ______________
Address: ______________ City: ________ State: ______ Zip Code: ________
Phone: ______________ Email: ______________
Date of Birth: ______________________________ Sex: ________
Who referred you? ______________________________

HISTORY
Exercise Frequency: ______________ Exercise Type(s): ______________
Do you smoke? ________ Have you ever smoked? ________ How often? ________
Are you pregnant? ______________ Do you have a pacemaker? ______________
Allergies: ______________________________
What medications are you currently using? ______________________________
Previous complaints/surgeries? ______________ Date of surgery: ________
Previous diagnoses/ medications: ______________________________
Primary Care Physician: ______________ Phone: ______________

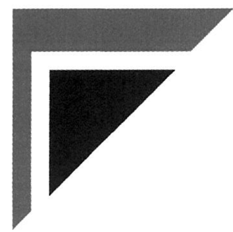
COMPLAINT
What is your major complaint? ______________________________
Start Date: ______________ Possible Cause: ______________
Symptoms: ______________________________
Previous Doctors seen for complaint: ______________________________
Symptom-Aggravating factors: ______________________________
Symptom-Relieving factors: ______________________________
Time of Day Symptoms are best: ________ Time they are the worst: ________
Current Duration of Pain: Intermittent ☐ Constant ☐ With Certain Motions ☐
Current Level of Pain: Mild ☐ Moderate ☐ Severe ☐ Excruciating ☐
Is your pain getting better or worse? ________ Have you had this injury before? ________

PLEASE CIRCLE IF YOU HAVE A HISTORY OF:

AIDS/HIV	Anemia	Angina	Arteriosclerosis
Arthritis	Asthma	Blood Clots	Bone Infection
Cancer	Chemical Dependency	Circulation Problems	Depression
Diabetes	Epilepsy	Eye Infection	Heart Problems
Hemophilia	High/ Low Blood Pressure	Joint/ Bone Infection	Liver Problems
Lung Issues	Multiple Sclerosis	Musculoskeletal	Pneumonia
Stroke	STD	Tuberculosis	Other: ________

SPOUSE AND/OR GUARDIAN
Name: ______________________________ DOB: ________
Relationship: ______________ Employer: ________ Occupation: ________
Emergency Contact: ______________ Relationship: ________ Phone #: ________

______________________________ ______________
Signature Date



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Release information: By signing below, I authorize the above-mentioned entities to release information regarding my appointments, treatments, and financial responsibilities to the following parties for up to seven years from the date of my signature below.

Name: ______________________________ Date: ____________________

Name: ______________________________ Date: ____________________

I have fully read and understand all the above context and agree to accept its term as rendered.

____
Signature of patient or responsible party

____
Print Name

____
Date

DRY NEEDLING CONSENT TO TREAT FORM

Dry needling (DN) is a skilled technique performed by a physical therapist using a single-use, single-insertion, sterile filiform needle, which is used to penetrate the skin or underlying tissue to effect change in body conditions, pain, movement, impairment and disability. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of the procedure:

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture, while rare, may require hospitalization.

Other risks may include bruising, infection or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration so please answer the following questions:

- **Are you taking blood thinners?** Yes / No
- **Are you or is there a chance you could be pregnant**? Yes / No
- **Are you aware of any problems or have any concerns with your immune system?** Yes / No
- **Do you have any known disease or infection that can be transmitted through bodily fluids?** Yes / No

Patient's Consent:

I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction.

My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I,____________________________________authorize the performance of (DN)

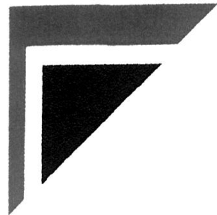
________________________________ ____________

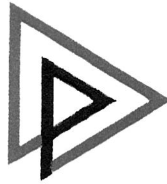
Patient or Authorized Representative Date

________________________________ ____________

Relationship to patient (if other than patient) Date

☐ I was offered a copy of this consent and refused.





PRISM
Pensivy Rehabilitation
Institute of Sports Medicine

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CONSENT MEDIA RELEASE FORM

Purpose of consent: By signing this form, you are consenting to allow PRISM P.T., LLC, PT ProCare, LLC, and FORS, LLC and any associate staff member to use your photo and/or video. You are also consenting to allow the foregoings entitled to use your photo, video, or testimony or endorsement regarding the service, treatment, or products used provided during your treatment.

By signing below, I agree and acknowledge that I have read and understood the above release and agree to all terms described. I am of legal age, at least 18 years old, and freely sign this release.

Signature　　　　　　　　Date

Printed name

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Late Cancellations/No-Show Policy

A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointment time. A no-show is when a patient misses an appointment without cancelling. In either case, there will be a $50.00 missed appointment fee charge.

Thank you for your understanding and respect for fellow patients and our providers here at PRISM P.T.

Signature: ______________________________

Date: ______________________________

PRISM PT LLC
6823 Ponderosa Way Las Vegas, NV 89118
702-655-4054

FINANCIAL POLICY

Thank you for choosing us as your physical therapy provider. We are committed to your health treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read, and sign prior to any treatment.

ALL patients must complete our Information and Insurance form before seeing the doctor or therapist.

*********FULL PAYMENT IS DUE AT THE TIME OF SERVICE********
*******We accept Cash, or Visa/MasterCard*********

Regarding Insurance:
We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us a correct insurance information and original identification card (copy). Please be aware that some, or perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or medical insurance. If we are not a participating provider, we are not a party to that contract, so unpaid balances will be your responsibility.

Regarding Insurance Plans where we are a participating provider:
All co-pays and deductibles are due prior treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider refer to the above paragraph.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

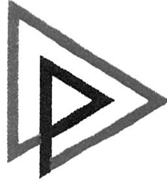
Regarding Records Request:
For Medical Records Requests there will be a .60 cent per page fee. Medical Records take 7-14 days to process. If a request is made to transfer records to a new provider, the fee is waived. There is a **$50-500.00** fee for any forms that need to be filled out by a doctor or therapist (i.e. DMV, Insurance, Disability, ETC.)

Missed Appointments:
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of **$50.00**. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know your questions or concerns. Prism PT LLC reserves the right to increase the amount charged for missed appointments, and medical records requests. Your signature below agrees to these terms. Your signature below indicates that you have read the Financial Policy. You understand and agree to this Financial Policy and agree that if your insurance company requires Pre-Authorization before treatment and you fail to comply you will be responsible for the charges incurred.

X ______________________ ______________
Signature of Patient Date

X ______________________ ______________
Signature of Parent or Guardian Date



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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____________________________
(PRINT NAME PLEASE)

Signature: ____________________________ Date: __________

Witness: ____________________________ Date: __________

A. Notifier: PRISM PHYSICAL THERAPY

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D.______________,below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D.,______________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy	Not a covered benefit.	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D.,______________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D.____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

X☐ **OPTION 2.** I want the D. PT treatments listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D.,____________ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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