Las Vegas Physical Therapy & Sports
7229 W Sahara Ave, Ste 105, Las Vegas, NV 89177
(702) 586-2177
frontdesk@lvpts.com

Patient Information

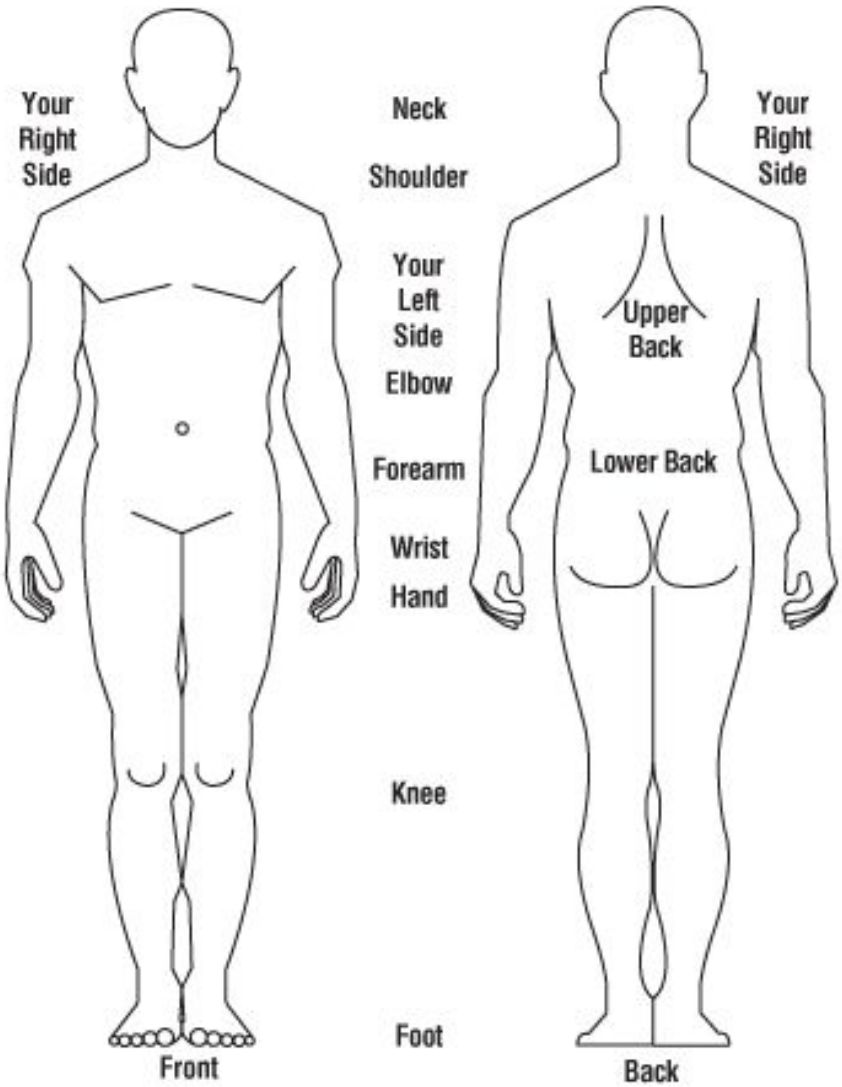
Name: _____**Date:** _____

Pain Location and Description

Using the diagram below, please indicate where you are experiencing pain or difficulty. Mark the areas using the following symbols:

- **XXX** = Burning Pain
- **000** = Pins & Needles or Numbness
- //// = Sharp or Stabbing Pain
- **ooo** = Aching or Throbbing Pain

Diagram



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Pain Intensity and Description

For each area you marked above, rate the intensity of your problem on a scale of 1-10, with **1 being low** and **10 being very severe**. Provide additional details to describe your symptoms.

Area (e.g., lower back, left leg)	Intensity (1-10)	Other Comments (e.g., constant, worse at night, helped by medicine, etc.)

Patient Acknowledgment

I have provided accurate information to the best of my ability and agree to share updates about my condition as necessary.

- **Patient Signature:** _____
- **Date:** _____

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COMPREHENSIVE TREATMENT CONSENT FORM

Patient Information

Name: _____ Date of Birth: _____
Address: _____Apt #: _____ City: _____ Zip:____

Consent for Treatment and Informed Consent

I hereby consent to receive physical therapy treatment and care provided by the licensed physical therapists and staff at Las Vegas Physical Therapy & Sports. I understand that my treatment may include physical therapy evaluations and assessments, therapeutic exercises and activities, manual therapy techniques, electrotherapy, ultrasound, dry needling, shockwave therapy (ESWT), laser therapy, vestibular rehabilitation, post-surgical rehabilitation, and other modalities deemed appropriate for my condition.

Understanding of Treatment

I acknowledge and understand that my treatment plan will be based on my individual evaluation and needs. I have the right to participate in planning my care and may refuse any treatment. While physical therapy is generally safe, there are potential risks including temporary pain, discomfort, soreness, bruising, swelling, skin irritation or burns (with certain modalities), infection (in rare cases, such as with dry needling), and fatigue after exercise. The physical therapy team will make every effort to minimize these risks. No guarantees have been made regarding the outcome of treatment, and I have the right to seek alternative treatment or decline services.

Financial Responsibility

I understand that I am responsible for all costs associated with my treatment as outlined in the separate financial policy. I agree to provide accurate insurance information and address billing inquiries promptly.

Authorization

I confirm that I have read and understand this consent form, have had the opportunity to ask questions about my treatment, and my questions have been answered satisfactorily. I voluntarily consent to receive physical therapy treatment under the conditions explained above.

Patient Signature: _____ Date: _____

Print Patient Name: _____

Representative Name: _____Relationship to Patient: _____

Representative Signature: _____ Date: _____

This form has been reviewed and approved by Las Vegas Physical Therapy & Sports. A copy of this signed consent will be provided upon request.

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RELEASE OF INFORMATION AUTHORIZATION FORM

- **Patient Name:** _____ **Date of Birth (DOB):** _____
- **Date of Injury:** _____ **Name of Guardian (if patient is a minor):**
- **Address:** _____**Apt #:** _____
- **City:** _____ **Zip:** _____

Authorization Details

I, _____, hereby request and authorize **Las Vegas Physical Therapy & Sports** (7229 W. Sahara Ave., Suite 105, Las Vegas, Nevada 89117) to release the requested information to:

- **Name/Organization:** _____
- **Address:** _____
- **Phone:** _____
- **Fax/Email:** _____

Information to Be Released

The following information is requested (check all that apply):

[ ] Medical Records [ ] Consultations
[ ] Lab Findings [ ] Evaluations/Assessments
[ ] Progress Notes [ ] Discharge Summary
[ ] Testing Records [ ] Alcohol/Drug Abuse Treatment Info
[ ] Social History [ ] HIV/AIDS Information
[ ] Treatment Plan(s) [ ] Other (specify): _____

Expiration of Authorization

This authorization will expire on: _____ (If left blank, authorization will expire one year from the date of signature.)

Acknowledgment and Understanding

1. Signing this authorization is voluntary, and I may refuse to sign this authorization.
2. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization.
3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
4. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal privacy regulations.
5. I may receive a copy of this authorization.

Signature

- **Signature of Patient or Guardian (if Patient is a Minor):**
  _____
- **Date:** _____

If signed by a legal representative:

- **Print Name of Patient or Guardian:**
  _____
- **Relationship to Patient (if not self):**
  _____

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HIPAA CONSENT AND AUTHORIZATION FORM

I understand my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and consent to the use and disclosure of my protected health information (PHI) for treatment, including coordination with other healthcare providers, obtaining payment from third-party payers, and the day-to-day healthcare operations of the practice. I acknowledge receiving access to the Notice of Privacy Practices, which explains how my PHI is used and disclosed. I understand this notice may be updated, and I can request a revised copy at any time.

Communication Authorization

I authorize Las Vegas Physical Therapy & Sports to contact me with appointment reminders, home exercise program updates, promotions, and other health-related information. Message and data rates may apply depending on my mobile carrier. I can manage these communications by replying **STOP** to end all communications for a specific method (e.g., text messages) and **HELP** for assistance or further information about the messaging service.

Consent and Preferences

☐ **Yes, I consent** to receive messages (e.g., appointment reminder, etc.).
☐ **No, I do not consent** to receive messages (e.g., appointment reminder, etc.).

If you consent, indicate your preferred methods of communication (check all that apply):
☐ **Text messages** to my cell phone
☐ **Email**: _____

I understand that I can withdraw my consent at any time by replying “STOP” to a text message or contacting the clinic in writing. Communications will comply with HIPAA and will only be used for purposes related to my healthcare.

Protected Health Information Release

I authorize the release of my PHI to individuals listed below:

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

Patient Rights

I understand I may request restrictions on the use and disclosure of my PHI, though the practice is not required to agree unless it chooses to do so. I may revoke this consent in writing, though any use or disclosure prior to revocation remains valid. I have the right to receive my PHI in an electronic format and request amendments to it.

Patient Information

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Guardian Name (if applicable): _____ Relationship: _____

Signature of Guardian: _____ Date: _____

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FINANCIAL POLICY AND PAYMENT AGREEMENT

Insurance and Payment Terms As a courtesy, we will submit insurance claims on your behalf. However, regardless of insurance coverage, you are ultimately responsible for all charges within 30 days of service. All co-payments, co-insurance, and deductibles are due at the time of service. Non-insured (self-pay) patients must pay all charges at the time of service. A convenience fee of $2.00 will be added to all credit card transactions.

Insurance Authorization: I authorize the release of any medical information necessary for my insurance carrier to process claims and request direct payment of any benefits to Las Vegas Physical Therapy & Sports. This authorization remains valid until rescinded in writing or replaced.

Guarantee of Payment: I acknowledge and accept full financial responsibility for all charges related to products and services provided to me or the person I am the responsible party, including any charges not covered by insurance.

Delinquent Account Terms: An account becomes delinquent if not paid within 30 days from the date of service. Delinquent accounts are subject to:

1. Interest charges of 24% per annum (2% monthly) on unpaid balances
2. Assignment to a collection agency without notice
3. Collection agency fees of 40% to 50% of the account balance
4. Reporting to all major credit bureaus
5. Legal action for collection, if necessary

Collection Costs: If legal action becomes necessary, the responsible party agrees to pay all collection agency fees, accrued interest, attorney fees, court costs, filing fees, service fees, skip tracing fees, and any additional costs awarded by the court.

Returned Check Policy: A $25.00 fee will be charged for any returned check, plus any applicable bank service fees. This fee is subject to change without notice.

Acknowledgment: I certify that I have read and fully understand this Financial Policy. I agree to all terms and conditions stated above. I understand that I am financially responsible for all charges, whether or not covered by insurance, payment is required within 30 days of service, and I must fulfill my financial obligations without delay. I am responsible for all charges whether or not I receive an invoice or payment reminder.

Patient/Responsible Party Information:

Signature: _____ Date: _____

Print Name: _____

Patient Name (if different): _____ DOB: _____

Relationship to Patient (if applicable): _____

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PATIENT CANCELLATION AND NO-SHOW POLICY

At **Las Vegas Physical Therapy & Sports**, we value your time and strive to provide personalized care to every patient. To ensure efficient scheduling and accommodate all patients, we have established the following cancellation and no-show policy:

1. **Appointment Cancellation:** If you need to cancel or reschedule an appointment, please notify us at least **24 hours in advance**. Cancellations can be made by calling +1 (702) 586-2177 during business hours or emailing frontdesk@lvpts.com. Voicemails or emails sent after hours will be processed the next business day.
2. **No-Show Policy:** A "no-show" occurs when a patient fails to attend a scheduled appointment without prior notification. Arriving more than **15 minutes late** without notice may also be considered a no-show.
3. **Fees for Late Cancellations and No-Shows:** A fee of **$25** will be charged for appointments canceled with less than 24 hours' notice or for no-show appointments. This fee is not covered by insurance and must be paid prior to scheduling future appointments.
4. **Exceptions:** We understand that emergencies and unavoidable circumstances may arise. Examples include sudden illness, accidents, or family emergencies. In such cases, please inform our office as soon as possible, and we will work with you to accommodate your needs.
5. **Recurrent Cancellations or No-Shows:** Patients who cancel or miss more than **three appointments within six months** may be required to prepay for future appointments or risk dismissal from care.
6. **Purpose of the Policy:** This policy helps ensure that our therapists' time is used efficiently and allows us to offer timely care to other patients who may be waiting for appointments.

Acknowledgment. I have read and understand the Cancellation and No-Show Policy for **Las Vegas Physical Therapy & Sports**. I agree to adhere to this policy and accept responsibility for any applicable fees associated with late cancellations or missed appointments.

Signature

- **Patient Signature:** _____
- **Date:** _____

If signed by a legal representative:

- **Name of Representative:** _____
- **Relationship to Patient:** _____
- **Signature of Representative:** _____
- **Date:** _____