



# PRUE

PHYSICAL THERAPY & SPORTS PERFORMANCE

## Patient/Client Contact Information

Male  Female

Mr.  Mrs.  Ms.  Dr.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Last Name                      First Name      MI                      DOB                      SSN

Street Address                      Apt/Unit/Suite                      City                      State                      Zip Code

Home Phone                      Mobile Phone                      Business Phone                      Email Address

Occupation                      Employer's or School Name                      Employer's or School Address

Emergency Contact                      Relationship                      Home Phone                      Mobile Phone

How did you hear about us? \_\_\_\_\_

Family Physician: \_\_\_\_\_                      Specialty Physician (if any): \_\_\_\_\_

### **Insurance Information (For Physical Therapy Patients Only)**

\_\_\_\_\_  
Name of Insured                      Payer/Plan                      Policy ID #                      Group #

Acknowledgements:

- I consent to treatment, be it physical therapy, massage therapy, or personal training services, necessary for the care of the above named patient/client. I also understand that there are risks associated with exercise and manual therapy that come with physical therapy, personal training, sports performance training and massage therapy including but not limited to the risk of personal injury.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I allow fax transmittal of my medical records, if necessary.
- I am fully financially responsible for services rendered by Prue Physical Therapy and Sports Performance, LLC and their professional staff.
- I understand that payment is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of any charges.
- I have read and fully understand the consent for treatment, financial responsibility and essential release of medical information clauses.

**Patient Name (please print):** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

*(Parent or Guardian if patient/client is under 18 years old)*



# PRUE

PHYSICAL THERAPY & SPORTS PERFORMANCE

## Medical History Form

Patient/Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Please describe any current injury or pain you are having (if not currently in pain please skip to the next question)

How it the injury occur/when did the pain start? \_\_\_\_\_

Where does it hurt? \_\_\_\_\_

Describe your pain (i.e. sharp, dull, shooting, aching, etc.): \_\_\_\_\_

On a scale from 0 (no pain) to 10 (most severe pain) rate your pain level:

Best/Lowest: \_\_\_/10    Right Now: \_\_\_/10    Worst/Most: \_\_\_/10

What makes your pain better/how do you decrease your pain/get relief?

\_\_\_\_\_

What movements, activities or situations make your pain or issue worse?

\_\_\_\_\_

Have you been treated previously for this condition?    Yes                  No

If yes, what treatments have you tried previously and were they effective?

\_\_\_\_\_

2. Please list any bone, joint, muscle or nerve injury from your past (include surgeries)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Please list any medications you are taking (both over-the-counter and herbal supplements):

\_\_\_\_\_

\_\_\_\_\_

4. Please list all medical current medical conditions or health concerns

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5. Do you exercise regularly (if yes please list type of exercise and frequency)? Yes No

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6. Do you currently smoke or use Tobacco? Yes NO

**Check any of the below conditions that previously or currently apply to you**

\_\_\_ Unexplained weight loss / gain

\_\_\_ Unexplained fatigue / weakness

\_\_\_ Fever, chills

\_\_\_ Cancer

\_\_\_ New or change in mole

\_\_\_ Rash / itching

\_\_\_ Breast lump / pain / nipple discharge

\_\_\_ Nosebleeds, trouble swallowing

\_\_\_ Frequent sore throat, hoarseness

\_\_\_ Hearing loss / ringing in ears

\_\_\_ Change in vision / eye pain / redness

\_\_\_ Chest pain / discomfort

\_\_\_ Palpitations (fast or irregular heartbeat)

\_\_\_ Heart Attack/MI

\_\_\_ Stroke (CVA)

\_\_\_ High Blood Pressure

\_\_\_ Cough / wheeze

\_\_\_ Short of breath with exertion

\_\_\_ Heart Burn/Reflex/Indigestion

\_\_\_ Bowel or bladder dysfunction

\_\_\_ Leaking urine

\_\_\_ Blood in urine

\_\_\_ Headache

\_\_\_ Memory loss

\_\_\_ Fainting

\_\_\_ Dizziness

\_\_\_ Numbness / tingling

\_\_\_ Unsteady gait

\_\_\_ Frequent falls

\_\_\_ Concussion

\_\_\_ Easy bruising

\_\_\_ Poor Wound Healing

\_\_\_ Heat or cold sensitivity

\_\_\_ Thyroid (hyper/hypo)

\_\_\_ Hepatitis/Liver Dysfunction

\_\_\_ Diabetes

\_\_\_ Arthritis

\_\_\_ Epilepsy/Seizure /Convulsions

\_\_\_ Hay fever / allergies

\_\_\_ Anxiety / stress / irritability

\_\_\_ Sleep problem

\_\_\_ Lack of concentration

**Women only**

\_\_\_ Problem with menstrual periods

\_\_\_ Hot flashes / night sweats

\_\_\_ Pregnancy (Current or within last 12 months)

Other: \_\_\_\_\_

Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_

Signature (Parent or Guardian if patient/client is under 18 years old):

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# Our Policies

## **Physical Therapy**

We are dedicated to providing highly individualized manual and therapeutic/functional exercise care for patients with sports or orthopedic injuries/pain. Your plan of care is achieved through the professional assessment of your therapist and physician, and is based on your specific needs.

## **Sports Performance/Personal Training**

We are dedicated to providing a highly individualized sports performance, injury prevention, weight loss and other personal training programs in order to meet your unique goals. The goals of this program will be achieved through professional assessment and implementation by a certified strength and conditioning coach or personal trainer in conjunction/overseen by a Doctor of Physical Therapy.

## **Massage Therapy**

We are dedicated to providing you with a massage therapy session or program based on your needs and goals. A licensed massage therapist will work with you to determine your goals and needs. The therapist will provide hands on soft tissue treatments.

## **Please carefully read the following policies and sign below.**

**1. Insurance:** Only physical therapy services are eligible for reimbursement through their insurance companies. In order to achieve the best possible results for our clients and maintain our industry leading standard of care, Prue Physical Therapy and Sports Performance LLC, does not bill third parties for payment. Payment is expected when services are rendered unless other arrangements are agreed upon by both parties (patient and Prue Physical Therapy and Sports Performance LLC) prior to services being rendered. Patient is fully responsible for knowledge of his/her own insurance benefits and reimbursement policies. Prue Physical Therapy and Sports Performance will make being reimbursed by your insurance provider as easy as possible providing all necessary records and documentation as needed.

**2. Automobile Accidents:** We do not bill auto insurance companies nor do we accept assignment on any automobile accident. We do not wait for settlement from attorneys or wait for settlement from any automobile carriers. Reimbursement for care can be obtained in the same way that clients are reimbursed from a health insurance carrier.

**3. Medicare:** We are not Medicare providers, and cannot bill Medicare for you. At this time we cannot accept clients who intend to bill Medicare. We can see patients that have Medicare for wellness visits and other services not normally reimbursed by Medicare.

**4. Durable Medical Equipment (DME) and Supplies:** Some DME and supplies are not reimbursable by insurance companies and must be paid for prior to ordering.

**5. Payment:** Payment is expected when services are rendered (each visit). For your convenience, we can accept payment on a weekly basis. If alternative arrangements are necessary, please contact us directly. We accept VISA, MasterCard, American Express, Discover, check and cash. **We expect accounts to be paid in full within 30 days from the last day of treatment.**

**6. Late Charges/Returned Checks:** Any account that remains open beyond 30 days from last date of treatment will be subject to a **\$10.00 fee** for each month that the account is not paid in full. There is a **\$35.00 fee** for all returned checks.

**7. Cancelled/Missed Appointments:** If a client is more than **15 minutes late** for an appointment, Prue Physical Therapy and Sports Performance LLC reserves the right to cancel or reschedule the treatment. **Late arrivals are subject to the full fee for the session.** We require **24-hour notice for cancellations.** Appointments that are cancelled with less than 24 hours' notice or no show appointments are subject to the full charge of the scheduled appointment, which is not reimbursable by insurance providers. Payment information on file will be used to make payments for missed or late canceled appointments; see associated documentation for more information.

**8. Right to Triage:** Prue Physical Therapy and Sports Performance will see each patient/client at their greatest convenience. However, we reserve the right to triage clients on emergency cases.

**9. Fees:** We reserve the right to alter the fee schedule without notice. Please see our latest fee schedule for physical therapy, sports performance/personal training and massage therapy services.

**10. Documentation:** The therapist reserves the right to allow documentation time during client treatments.

**11. Consent for Treatment:**

**Physical Therapy:** The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures. Your physical therapist will monitor your progress and adjust your treatment duration and frequency accordingly.

**Sports Performance/Personal Training:** The client hereby consents to the administration of appropriate evaluation and implementation of appropriate exercise/training programs. Your strength and conditioning coach/personal trainer will monitor your progress and adjust program accordingly.

**Massage Therapy:** The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures. Your massage therapist will monitor your progress and adjust your treatment duration and frequency accordingly.

**12. Our Pledge Regarding Medical Information:** We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Prue Physical Therapy and Sports Performance LLC.

We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Prue Physical Therapy and Sports Performance LLC. We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.

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I have read the above policies and understand that payment is due when services are rendered. I agree to accept full financial responsibility for medical expenses incurred at Prue Physical Therapy and Sports Performance LLC.

If patient is under 18 years of age, and a parent is not able to attend sessions of physical therapy, sports performance/personal training or massage therapy with the minor, the parent(s) signature for authorization allows Prue Physical Therapy and Sports Performance to commence physical therapy treatments, sports performance training or massage therapy with the patient/client who is a minor. The parent(s) is also accepting full financial responsibility for the treatment.

**Patient/Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Parent or Guardian if patient/client is under 18 years old)*

# **Notice of Privacy Practices Prue Physical Therapy and Sports Performance LLC**

This notice describes how medical information about you may be used and disclosed, and how you can access this information.

## **1. Uses and Disclosures of Protected Health Information**

Prue Physical Therapy and Sports Performance will use or disclose your protected health information (PHI) as described in this section. Your PHI may be used and disclosed by Prue Physical Therapy and Sports Performance, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of Prue Physical Therapy and Sports Performance LLC. Following are examples of the types of uses and disclosures your PHI that Prue Physical Therapy and Sports Performance LLC is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.

**Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This may include doctors, nurses, technicians, other physical therapists, or other providers who have referred you for services or are involved in your care. For example, we may feel that a patient we are treating for chronic low back pain would benefit from an evaluation by a pain specialist to address pharmacological pain management. The health information we share with the pain specialist would be considered a treatment related disclosure.

**Payment:** Your PHI will be used, as needed, to obtain payment for your health care services. This may include the disclosure of health information to your physician, insurance company for certain activities before it approves or pays for the health care services recommended, such as: reviewing services provided to you for medical necessity and undertaking utilization review activities.

**Health Care Operations:** We may use or disclose, as-needed, your PHI in order to support the business activities of Prue Physical Therapy and Sports Performance LLC. These activities include, but are not limited to, quality assessment activities, employee review activities, training of clinical students and staff, licensing, marketing, and conducting or arranging for other business activities. For example, we may disclose your PHI to physical therapy, strength and conditioning or massage therapy students treating patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use your name and PHI for patient flow tracking in the office. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment. We will share your PHI with third party business associates that perform various activities such as billing and transcription.

**Other Special Uses:** Prue Physical Therapy and Sports Performance may use your PHI to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

## **Uses and Disclosures Required by Law:**

The federal health information privacy regulations neither permit nor require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if you are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

**2. Your Privacy Rights:**

**Restrictions:** You have the right to request restrictions on how your PHI is used. However, we are not required to agree with your request. If we do agree, we must abide by your request. You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

**Access to PHI:** You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing. Any requests that your medical record be sent to a third party of your choosing must also be made through a written request that clearly identifies the relevant third party and grants express permission to release records to that third party.

**Amendments:** You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

**Accounting of Disclosures:** You have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

**Complaints:** If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

**Our Duty to Protect Your Privacy:** We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

**Privacy Contact:** If you would like more information about our privacy practices or to file a complaint you may contact:

Dr. Kevin Prue, PT, DPT, CSCS

1020 Southhill Drive

Cary NC, 27513

Kevin.prue@pruept.com

555-555-5555

I have reviewed and understand the Notice of Privacy Practices for Prue Physical Therapy and Sports Performance LLC.

**Patient/Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Parent or Guardian signature if patient/client is under 18 years old)*



# **Prue Physical Therapy and Sports Performance LLC Financial Policy**

Prue Physical Therapy and Sports Performance LLC operates as an out-of-network provider for most insurance plans. Physical therapy services are the only services eligible for reimbursement through a patient's insurance company. We believe that insurance companies should not dictate the care you receive and in clinics that accept all manner of third party payment, that's exactly what happens. Our patients demand a higher level of customer service and expert care.

In order to maintain our industry leading standards and individualized treatment sessions, Prue Physical Therapy and Sports Performance LLC will not directly bill or negotiate with insurance companies. In order to decrease the administrative load on our clients so they can concentrate on maximizing their healing and improvement, we at Prue Physical Therapy and Sports Performance have developed a system to submit claims to insurance companies for patient reimbursement. Patients have had great success with reimbursement using the documentation we provide. At this time we cannot accept clients who intend to bill Medicare for services rendered. However we can accept Medicare recipients for wellness visits and other services not normally reimbursed through Medicare.

Sports Performance/Personal Training and Massage Therapy services are not eligible for reimbursement through insurance. These services must be paid at the time service is rendered unless a payment plan is arranged and agreed upon by both the patient/client and Prue Physical Therapy and Sports Performance LLC.

Special packages, discounts and promotions being run by Prue Physical Therapy and Sports Performance for physical therapy, sports performance/personal training, and massage therapy will be applied prior to request for payment.

## **Billing & Fee Schedule**

- Payment is expected when services are rendered
- The patient is responsible for all charges for services provided by Prue Physical Therapy and Sports Performance

## **Current Physical Therapy Fee Schedule**

**60-minute Physical Therapy Evaluation: \$125.00**

**60-minute Physical Therapy Long Treatment: \$125.00**

**30-minute Physical Therapy Short Treatment: \$65.00**

- Reimbursement documentation can be submitted by Prue Physical Therapy and Sports Performance LLC to insurance companies on a monthly basis unless otherwise specified. Patients may still choose to submit their own insurance claims

## **Current Sports Performance/Personal Training Fee Schedule**

**1 Sports Performance/Personal Training Session: \$65**

**8 Session Package: \$480**

**12 Session Package \$690**

## **Current Massage Therapy Fee Schedule**

**90 minute session: \$90**

**60 minute session: \$65**

**30 minute session: \$45**

I have read the Prue Physical Therapy and Sports Performance Financial Policy and understand that the patient/client is ultimately responsible for all charges for services provided by Prue Physical Therapy and Sports Performance. I also understand that appointments that are cancelled with less than 24hours notice or no show appointments are subject to full charge.

**Patient/Client's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Parent or Guardian if patient/client is under 18 years old)*