TRINITY REHABILITATION & SPORTS MEDICINE, INC.

TRINITY REHABILITATION ADMISSIONS FORM

Appointment Date ____/____/____ Appointment Time ____

PATIENT INFORMATION

Patient Name (Last) ____ (First) ____ (MI) ____
Social Security # ____ DOB (Month/Day/Year) ____
Address ____
City ____ State ____ Zip ____ Email Address ____
Home Phone # ____ Cell# ____ Sex: F / M Marital Status: M S D W
Employer ____ Work Phone# ____ Ext. ____
Employer Address ____ City ____ State ____ Zip ____
Person to contact in case of emergency (not living with you): Name ____ Phone # ____

RESPONSIBLE PARTY INFORMATION SELF SPOUSE OTHER

Name ____ Social Security # ____ DOB (Month/Day/Year) ____
Address ____ City ____ State ____ Zip ____
Phone # ____ Employer ____
Address ____ City ____ State ____ Zip ____

PHYSICIAN INFORMATION PT OT ST WH DME AQUATIC SPLINT FCE

Primary Care Physician ____ Phone ____ Fax ____ UPIN# ____
Referring Physician ____ Phone ____ Fax ____ UPIN# ____
Diagnosis on Doctor's referral order ____
____ Onset date ____

PRIMARY INSURANCE

Insurance Co. ____
Address ____
City ____ State ____ Zip ____
Phone # ____
Policyholder ____ DOB ____
Policy # ____ Group # ____

SECONDARY INSURANCE

Insurance Co. ____
Address ____
City ____ State ____ Zip ____
Phone # ____
Policyholder ____ DOB ____
Policy # ____ Group # ____

WORKERS COMP.

Company Name ____ Contact Name ____ Phone ____
Worker's Comp Carrier ____ Claim # ____
Address ____ City ____ State ____ Zip ____
Phone # ____ Ext. ____ Adjuster Name ____ Authorization# ____

AUTO ACCIDENT

Insurance Company ____
Adjuster Name ____ Phone ____ Ext. ____ Claim # ____
Address ____ City ____ State ____ Zip ____
Date of Accident ____ Attorney Name ____ Phone# ____

Intake completed by _____ *Date* _____

TRINITY REHABILITATION & SPORTS MEDICINE, INC.

PATIENT ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as assessments and physician certifications.

By signing this document, I acknowledge that you have provided me with a copy of your **Notice of Privacy Practices**. The **Notice of Privacy Practices** contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the addresses below to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound by such restrictions.

Patient Name..... Date .....

Signature.....

Relationship to Patient .....

Does Trinity Rehab. have permission to leave a message at your home phone number? Yes ☐ No ☐

Does Trinity Rehab. have permission to contact you at work? Yes ☐ No ☐

Does Trinity Rehab. have permission to disclose your presence or arrival for therapy services? Yes ☐ No ☐

These forms are provided as a service to subscribers to HHS.gov, and do not constitute legal advice. We try to provide information, but all forms should be reviewed by competent counsel to ensure that they apply correctly to the laws and regulations in your state.

TRINITY REHABILITATION & SPORTS MEDICINE, INC.

MEDICAL HISTORY

Patient Name: ..... Age ..... Date .....

PLEASE CHECK THE FOLLOWING AS IT APPLIES TO YOU

Heart disease	Yes ☐ No ☐	Dementia /Alzheimer's	Yes ☐ No ☐
Congestive heart failure	Yes ☐ No ☐	Back injury / Back pain	Yes ☐ No ☐
High blood pressure	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
COPD	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Osteoarthritis	Yes ☐ No ☐
Pacemaker or Defibrillator	Yes ☐ No ☐	Rheumatoid Arthritis	Yes ☐ No ☐
Headaches	Yes ☐ No ☐	Joint replacement	Yes ☐ No ☐
Dizzy spells	Yes ☐ No ☐	Difficulty walking	Yes ☐ No ☐
Fainting spells	Yes ☐ No ☐	Respiratory problems	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Seizures	Yes ☐ No ☐	Hepatitis A, B or C	Yes ☐ No ☐
Bladder or Bowel incontinence	Yes ☐ No ☐	HIV Positive	Yes ☐ No ☐
Depression	Yes ☐ No ☐		

Are you currently pregnant or trying to become pregnant? Yes ☐ No ☐

Are you allergic to any medications? Yes ☐ No ☐ If yes, please list below:

List Current Medications

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List Previous Surgeries and Year

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TRINITY REHABILITATION & SPORTS MEDICINE, INC.

AUTHORIZATION FOR TREATMENT
ASSIGNMENT OF MEDICAL BENEFITS & PAYMENT RESPONSIBILITY

AUTHORIZATION FOR TREATMENT: I hereby authorize the therapist in charge of my care and TRINITY REHABILITATION INC. to perform upon me such therapeutic procedures, and render such medical care as their judgment may indicate as necessary and advisable as per doctors orders.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize TRINITY REHABILITATION INC. and/or any treating physician to release to the insurance carrier liable for all or part of TRINITY REHABILITATION INC. charges, only such diagnostic and therapeutic information (including psychiatric, drug abuse, alcohol) as may be necessary to determine benefits entitlement and to process payment claims for health care services provided to me, commencing on this date. This authorization shall be valid only for the period of time necessary to process claims pertaining to this service, but in any case, shall cease to be valid six months from this date.

MEDICARE/MEDICAID/PATIENT CERTIFICATION/RELEASE INFORMATION & PAYMENT REQUESTS: I certify that the information given by me in applying for payment under Title XVII, of the Social Security act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries or carriers any information needed for this or a related Medicare claim. I request that payments of authorized benefits be made on my behalf. I assign the benefits payable for therapists to submit a claim to Medicare for payment. I understand that I am responsible for any health insurance deductible and co-payments.

DENIAL OF PAYMENT/AUTHORIZATIONS: TRINITY REHABILITATION INC. will make every effort to obtain payment authorization/pre-authorization for all managed care contractual or Medicare supplemental agreements unless prohibited by contractual agreement: I agree I shall be jointly and severally financially responsible for any portion of TRINITY REHABILITATION INC. invoice that is not paid, except in the event of Medicare denial or Medicaid recipients where applicable.
Assignment of Insurance Benefits: I hereby authorize, request and direct any and all assigned insurance companies to pay directly to TRINITY REHABILITATION INC. the amount due me in my pending claims for benefits under the respective policies. I agree that, should the amount be insufficient to cover the entire expense, I will be responsible for payment of the difference, and that if the nature of the disability be such that it is not covered by such policy, I will be responsible to TRINITY REHABILITATION INC. for payment of the entire bill. I agree that TRINITY REHABILITATION INC. or any collection or servicing agency retained by the above, may contact me by telephone or text message, or email; which may result in a fee for the call or text message, for any money owed to TRINITY REHABILITATION INC. I also understand that I may also be contacted by automatic dialing devices and through pre-recorded messages or voice mail messages. If any action or law of inequity is brought to enforce this agreement, TRINITY REHABILITATION INC. shall be entitled to reasonable attorney's fees, court costs, and any other costs of collection incurred. I understand that all bills are payable and become due upon presentation. I and/or patient agree to execute any document and perform any acts that TRINITY REHABILITATION INC. may reasonably request the undersigned warrant and represent that the attached are originals, or certified copies of any applicable powers of attorney, health care surrogate forms, or court orders appointing the undersigned as the legal guardian of patient. I acknowledge that Trinity Rehabilitation Inc. has disclosed to the undersigned that no physician owns any interest in provider. I have read this contract and understand it. I will receive a copy upon request.

Patient's signature.....Date .....
Patient's signature/financially responsible party/legal representative.

TRINITY REHABILITATION & SPORTS MEDICINE, INC.
FINANCIAL POLICY OF TRINITY REHABILITATION

Thank you for choosing Trinity Rehabilitation for your therapy needs. We hope that we provide you not only with excellent care, but that you find our financial policies fair and equitable. It is our sincere desire to provide you with high quality, cost effective and affordable therapy services.

During your treatment, payment for the portions of the services you are responsible for (such as co-payments or services not covered by your insurance) is expected in full either at the time of service, or on a weekly basis. It is our preference that you use existing assets, credit, or other means to pay for your out-of-pocket therapy expenses, so we gladly accept cash, checks and credit cards.

The nature of some insurance plans makes it difficult for us to determine the exact amount you will be responsible for prior to billing your insurance. In such cases, we will estimate your portion, with the understanding that adjustments to your account will be made as we receive payment advisories from your insurance company.

We also understand that for any number of reasons, you may not be able to pay at the time of service. If you are unable to pay in full at the time of service, or if doing so would cause undue financial hardship, please ask our office personnel about establishing credit and a monthly payment agreement.

In situations where the party responsible for paying for your therapy is unclear, where it is likely that payment will be delayed more than 90 days, or if credit in excess of $300 is needed (such as a motor vehicle accident, denied worker's compensation claim, or lawsuits), we will either require you to pay for services at the time you receive them, make other arrangements for payment, or require you establish credit and a monthly payment agreement. This practice not only limits our risk, but limits your financial risk as well. Again, thank you for choosing Trinity Rehabilitation. If you have any questions or concerns about our financial policies, please feel free to discuss them with our staff.

TRINITY REHABILITATION & SPORTS MEDICINE, INC.

PATIENT PAYMENT AGREEMENT

I, ...Agree to pay Trinity Rehabilitation Inc.: $.....

(Copay per visit): ..... %, or ..... (any amounts not covered by insurance/or weekly/monthly payment).

The above will stand true until balance is paid in full by responsible party, or until rescinded in writing by Trinity Rehabilitation Inc. for all therapy services rendered.

I understand that although my insurance has been verified, this may not hold true with payment. If this happens, I understand I am responsible for amount shown on EOB (Explanation of Benefits), and if I have any questions, I can call Trinity's Billing department (479) 751-7122.

Patient/responsible party.....Date .....

Clinic Representative.....Date .....

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