TRIO REHABILITATION & WELLNESS SOLUTIONS

NEW PATIENT INFORMATION

Name

Address

City/State Zip

GENDER: ❍ MALE ❍ FEMALE

DOB SSN

Please select two preferred contact methods

❍ HOME PHONE _____

❍ CELL PHONE _____

❍ TEXT MESSAGE_____

❍ EMAIL _____

Emergency Contact

Relation To You Phone

Referring Doctor

Dr. Phone Number

Primary Care Dr.

Dr. Phone Number

IS INJURY FROM: ❍ AUTO ❍ WORK ❍ OTHER

Body Part Affected

Have your had physical therapy this year? ❍ YES ❍ NO

Does a nurse or therapist currently come to your home? ❍ YES ❍ NO

Date Of Onset/Injury

Patient Agreement - Please Read Carefully

I authorize treatment of the patient named above and agree to pay all charges for such treatment that may or may not be covered by my insurance. I also authorize the provider to release any information to referring/consulting physicians or other health care providers that may be necessary to facilitate care. I hereby authorize my insurance benefits to be paid directly to Trio Rehabilitation & Wellness Solutions. I certify that a copy of this agreement shall be valid as the original.

Patient or Legal Guardian Signature Date

Insurance Policy Information

Insurance Company

Identification Number

Group Number

Primary Insured Name

Relation To Patient

Primary Insured DOB

❍ Insurance Card Provided

Secondary Health Insurance

Insurance Company

Identification Number

Group Number

Primary Insured Name

Relation To Patient

Primary Insured DOB

❍ Insurance Card Provided

How did you hear about us?

❍ HEALTHCARE PROVIDER ❍ FAMILY/FRIEND

❍ INTERNET ❍ SOCIAL MEDIA

❍ EVENT ❍ OTHER_____

Effective 4/15/2020 and in response the COVID-19 pandemic, I consent to Telehealth services if applicable or so requested. These services may include Telehealth visits, virtual check-ins, and/or e-visits.

Patient or Legal Guardian Signature

Date

TRIO REHABILITATION & WELLNESS SOLUTIONS

FINANCIAL POLICY - READ CAREFULLY AND SIGN

It is your responsibility to know the limitations and restrictions of your insurance company regarding physical therapy. By signing below you hereby authorize your insurance benefits to be paid directly to Trio Rehabilitation & Wellness Solutions. You are responsible for paying your balance regardless of your insurance company's payments. **Copays are due at the time of service.** If your insurance company does not cover therapy and you choose to pay out of pocket for treatment, your balance is due at the time of your appointment.

In the event it should become necessary to forward your unpaid balance to a collection agency, you agree to pay interest and collection fees. If legal action is taken against your account, you agree to pay all reasonable attorney fees, filing fees and any other costs associated with this action. Checks returned without sufficient funds will be charged a $35.00 fee.

Patient or Legal Guardian Signature Date

Missed Appointments & Cancellations: appointments not kept or cancelled without 24 hours notice prior to the scheduled appointment time will be charged a **$50.00 cancellation fee.** These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid at the next scheduled appointment. If you miss 3 appointments without proper notice, all future appointments will be cancelled.

Patient or Legal Guardian Signature Date

PRIVACY POLICIES STATEMENT/HIPAA

You have the opportunity to review and question our privacy policies statement at your request. This statement outlines our policies that protect your privacy. We will release your personal health information for billing purposes to be reimbursed for services rendered or to facilitate your care with another of your health care providers. You may request (in writing) to prevent us from doing so without penalty or cessation of your care. If you exercise this right, you will be responsible for your balance and it will be your responsibility to submit claims to your insurance carrier for reimbursement.

Patient or Legal Guardian Signature Date

TRI REHABILITATION & WELLNESS SOLUTIONS

PATIENT HEALTH QUESTIONNAIRE

NAME _____ WEIGHT _____ HEIGHT _____ AGE _____ GENDER _____

CHECK ALL BOXES THAT APPLY

Have you or any immediate family member ever been told you have:

	YOU	FAMILY
Dementia	❍	❍
Fibromyalgia	❍	❍
Fracture	❍	❍
Cancer	❍	❍
High Blood Pressure	❍	❍
Diabetes	❍	❍
Heart Disease	❍	❍
Angina/Chest Pain	❍	❍
Stroke	❍	❍
Arthritis	❍	❍
Parkinsons Disease/ Movement Disorder	❍	❍

Do you have a history of:

- ❍ Shortness of Breath
- ❍ Allergies
- ❍ Asthma
- ❍ Bronchitis
- ❍ Kidney Disease/Stones
- ❍ Polio
- ❍ Emphysema
- ❍ Anemia
- ❍ Rheumatic Fever
- ❍ Ulcers

With current problem do you experience:

- ❍ Nausea/Vomiting
- ❍ Fever/Chills/Sweats
- ❍ Unexplained Weight Change
- ❍ Numbness or Tingling
- ❍ Bowel or Bladder Changes
- ❍ Dizziness
- ❍ Pain
- ❍ Headaches
- ❍ Muscular Weakness
- ❍ Surgery

For this problem have you received treatment from:

- ❍ Orthopedist
- ❍ Physiatrist
- ❍ Neurosurgeon
- ❍ Chiropractor
- ❍ Massage Therapist
- ❍ Osteopath
- ❍ Acupuncturist
- ❍ Psychologist
- ❍ Other Physical Therapist
- ❍ Other _____

Have you had any recent illness, to include upper respiratory infections (flu) or urinary tract infections?

❍ NO ❍ YES

Describe: _____

How often do you feel stress is a significant factor in your life?

❍ Never ❍ Seldom ❍ Regularly ❍ Always

Date of last complete physical examination?

_____

Do you smoke? ❍ No ❍ Yes

How many packs? _____

For how long? _____

Do you drink alcohol? ❍ No ❍ Yes

# of drinks per week? _____

List regular exercise/activity: _____

Other comments: _____

18 Scenic Loop Rd. Suite 200-A, Boerne, TX 78006 | 830.755.6091 | TRIOrehab.com | info@TRIOrehab.com

TRIO REHABILITATION & WELLNESS SOLUTIONS

Trio Rehab

Patient Name DOB

Medication	Dose	Date Taken	Date Started	Reason for Taking	Who told me to take this?

TRIO REHABILITATION & WELLNESS SOLUTIONS

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PHOTO/VIDEO AND/OR TESTIMONY

Patient Name

Date

Signature

If Personal Representative

Name:

Date:

Signature:

Relationship to Patient:

If Patient is a Minor

Parent / Legal Guardian:

Date:

Practice Name: Signature:

❑ I affirm that I have read this contract to likeness and release, and I fully understand the consent, meaning and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

OFFICE USE ONLY

Copy provided by

As a current patient of Trio Rehabilitation & Wellness Solutions I hereby authorize the attending therapist or other designated person to:

Photograph me for identification purposes. ❑ Yes ❑ No

Photograph appropriate parts of my body in order to provide supporting documentation for my medical condition. *(I understand that any photographs taken will be placed in and remain part of my medical record.)* ❑ Yes ❑ No

Telehealth Clause: Photograph/video appropriate parts of my body to provide Telehealth services ad support documentation for my medical condition. *(I understand that any photographs or videos taken will be placed in and remain part of my medical record).* ❑ Yes ❑ No

Photograph me the purpose of internal and external advertising, public relations, or collateral materials including but not limited to posting on Trio Rehabilitation & Wellness Solutions' website and social media sites. ❑ Yes ❑ No

Authorization: I authorize the use and disclosure of my name, photo, video, and/or testimonial for marketing purposes by Trio Rehabilitation & Wellness Solutions. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: Photo, videos, and/or testimonial will be used for internal and external advertising, public relations, or collateral materials including but not limited to posting on Trio Rehabilitation & Wellness Solutions' website and social media sites.

Advertising Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:
❑ "Yes, I would like a copy of this form."