TRIO REHABILITATION & WELLNESS SOLUTIONS

Name _____ Date of Birth _____

Address _____

City/State _____ Zip Code _____

GENDER ○ MALE ○ FEMALE

Please select two preferred contact methods

○ HOME PHONE _____

○ CELL PHONE _____

○ TEXT MESSAGE _____

○ EMAIL _____

Emergency Contact _____

Relation to You _____ Phone _____

Referring Doctor _____

Doctor Phone Number _____

Primary Care Doctor _____

Doctor Phone Number _____

IS INJURY FROM: ○ AUTO ○ WORK ○ OTHER

Body Part Affected _____

Have you had physical therapy this year? ○ YES ○ NO

DOES A NURSE OR THERAPIST CURRENTLY COME TO YOUR HOME? ○ YES ○ NO

Date of Onset/Injury _____

How did you hear about us?

○ HEALTHCARE PROVIDER ○ FAMILY/FRIEND

○ INTERNET ○ SOCIAL MEDIA

○ EVENT

○ OTHER: _____

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 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 authorize Trio Rehabilitation & Wellness Solutions to contact me regarding my care, appointments, and clinic-related information by phone, text message, or email using the contact information I have provided. I certify that a copy of this agreement shall be valid as the original.

Patient or Legal Guardian Signature _____ Date _____

Photo & Social Media Authorization

Trio Rehabilitation & Wellness Solutions may occasionally photograph or video patients for use on our website and social media platforms, such as Facebook and Instagram. These images may be used to share patient success stories, highlight our services, or promote our practice.

By signing below, you authorize Trio Rehabilitation & Wellness Solutions to use your name, photograph, and/or video in marketing materials, on our website, and on social media. Your participation is completely voluntary and will have no effect on the quality of your care. You may revoke this authorization at any time by submitting a written request to our office.

○ **Yes**, I authorize Trio Rehabilitation & Wellness Solutions to use my photo/video on the website and social media.

○ **No**, I do not authorize the use of my photo/video.

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PATIENT HEALTH QUESTIONNAIRE

CHECK ALL BOXES THAT APPLY

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

	YES	NO
Dementia	❍	❍
Fibromyalgia	❍	❍
Fracture	❍	❍
Cancer	❍	❍
High Blood Pressure	❍	❍
Diabetes	❍	❍
Heart Disease	❍	❍
Angina/Chest Pain	❍	❍
Stroke	❍	❍
Arthritis	❍	❍
Parkinson Disease/Movement Disorder	❍	❍
Osteoporosis	❍	❍
HIV/AIDS	❍	❍
Any other infectious diseases	❍	❍

Do you have a history of:

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

Which 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
- ❍ Other: _____
- ❍ Osteopath
- ❍ Acupuncturist
- ❍ Psychologist
- ❍ Other Physical Therapist

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

❍ YES ❍ NO

Describe: _____

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

❍ Never ❍ Seldom ❍ Regularly ❍ Always

Do you smoke? ❍ YES ❍ NO

How many packs? _____

For how long? _____

List regular exercise/activity: _____

Medications & dosage (you may attach or bring a current medication list):

Surgical History:

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ATTENDANCE & APPOINTMENT POLICY - READ CAREFULLY AND SIGN

Your appointments and progress are important to us. These policies help support consistent care and keep appointment times available for patients who need them.

Our Policies:

Attendance: Patients are expected to maintain an attendance rate of 80% or greater throughout the plan of care. If attendance falls below 80%, we will work with you to identify scheduling options that support consistent participation. Continued difficulty maintaining attendance may result in cancellation of standing appointments or discharge from therapy.

Card on File: A valid credit or debit card is required to remain securely on file. Applicable late cancellation/no-show fees will be automatically charged, including the initial evaluation.

Cancellation Deadline: Please cancel or reschedule by 3:00 PM on the business day before your appointment to allow our team to offer your appointment to another patient who may be waiting for care.

Treatment Late Cancellation/No-Show Fee: Treatment appointments canceled after the deadline or missed without notice are subject to a $50 fee. This fee is the patient's responsibility and cannot be billed to insurance.

Evaluation Late Cancellations/No-Show Fee: If you cancel or reschedule by 3:00 PM on the business day before the evaluation, the $50 remains as a credit on your account and may be applied to the rescheduled appointment.

Late Arrival: If you arrive more than 5 minutes late, your visit may need to be shortened or rescheduled. If we cannot accommodate the appointment, the applicable late cancellation fee will apply.

AI Scribe Disclosure: Trio Rehabilitation & Wellness Solutions uses an artificial intelligence (AI)-assisted scribe during your care to help create clinical documentation. This notice is provided to inform you of our use of AI-assisted documentation in connection with your health care.

I have read, understand, and agree to the policies above and authorize Trio Rehabilitation & Wellness Solutions to charge my card for applicable late cancellation/no-show fees.

Patient or Legal Guardian Signature Date

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FINANCIAL POLICY - READ CAREFULLY AND SIGN

It is your responsibility to know the limitations and restrictions of your insurance company regarding physical, occupational, and/or speech 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. Balances 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.

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