

Tririga Rehab, LLC

800 W LONG LAKE RD, SUITE 103

BLOOMFIELD HILLS, MI 48302

Phone: (248) 480-0900 Fax: (248) 282-8416 Email: tririgarehab@gmail.com

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Home Ph:(____)_____-_____
DOB: _____ SSN#:_____-_____-_____
Address: _____ Alt/cell:(____)_____-_____
Street Address _____ Email: _____
_____, _____, _____
City State Zip

Emergency contact: _____ Ph:(____)_____-_____

Relationship: Father/Mother Spouse Son/Daughter Friend Neighbor Other: _____

TYPE OF CLAIM:

Auto Accident Private Pay Other: _____

Insurance Information:

Auto Insurance Company: _____ Date of Injury ____/____/____

Amount of Deductibles: \$ _____ Coordinating Benefits Non-Coordinating Benefits

Claim Number: _____ Policy Number: _____

Adjusters Name: _____ Phone Number: (____)_____-_____

Mailing Address: _____, _____, _____
Street Address City State Zip

Secondary Health Insurance: _____

Address: _____

Phone Number: (____)_____-_____

Policy Number: _____ Group Number: _____ Plan Code: _____

Policy Holders Name: _____ Relationship: _____

Attorney: _____ Firm: _____

Address: _____

Phone Number: (____)_____-_____ Fax Number: (____)_____-_____

FOR BILLER USE:

VERIFIED ON: _____

COMMENTS:

PAST MEDICAL HISTORY, CHECK ALL THAT APPLY:

High Blood Pressure Yes No

Diabetes Yes No

Family History of Diabetes Yes No

Any Heart Problems Yes No

Family History of Heart Problems Yes No

Any EKG changes Yes No

Any broken bones Yes No

Any metal / plates / screws Yes No

Any surgery before Yes No Year of Surgery: _____ Site: _____

Diagnosed for Cancer Yes No

Any Previous Auto/Car accident Yes No Year(s) of Occurrence: _____

If so, Is Claim still open Yes No

Any dizziness Yes No

Any Skin Diseases Yes No

Had Physical Therapy before Yes No Date of Discharge: _____

Reason for Discharge _____

Any additional information _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I AM AWARE OF THE NOTICE OF PRIVACY PRACTICE AND I HAVE BEEN PROVIDED AND OPPORTUNITY TO REVIEW IT.

NAME: _____ **BIRTHDATE:** _____
(PRINT NAME)

SIGNATURE: _____ **DATE:** _____

Consent for Purpose of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct operation of this establishment. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to the restrictions that I may request. However, if the practice agrees to a restriction that I have requested, then they are bound by the restriction and I have the right to revoke this consent, in writing at any time, except to the extent that they have taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physician, mental health or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review their Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations. This Notice of Privacy Practices also describes my rights and duties of this establishment with respect to my protected health information. This establishment reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of Establishment: TRIRIGA REHAB, LLC, LLC

Patient Name: _____

Patient Signature: _____ Date: _____

If Personal Representative (Name): _____

Personal Representative Signature: _____ Date: _____

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MEDICAL LIEN FORM

To: Firm Name: _____

Address: _____

Attorney: _____

RE: Client: _____

I do hereby authorize TRIRIGA REHAB, LLC, LLC to furnish you, my attorney, with a full report of the examination, treatment, prognosis, etc. of myself in regards to the accident in which I was involved, occurring on or about (date).

I hereby give a lien to TRIRIGA REHAB, LLC, LLC on the proceeds of any settlement, claim, judgment, or verdict as a result of said accident, and authorize and direct you, my attorney to pay directly to TRIRIGA REHAB, LLC, LLC for services rendered to me and to withhold such sums from the proceeds of such settlement, claim judgment or verdict as may be necessary to protect TRIRIGA REHAB, LLC, LLC. I fully understand that I am directly and fully responsible to TRIRIGA REHAB, LLC, LLC for all medical bills submitted by TRIRIGA REHAB, LLC, LLC for services rendered to me and this agreement is made solely for TRIRIGA REHAB, LLC, LLC for additional protection and in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said charges for treatment.

Patient's Signature

Date

I undersigned, being attorney of record for the above patient, do hereby acknowledge receipt of the above lien and do agree to honor the same to protect TRIRIGA REHAB, LLC, LLC adequately.

Attorney's Signature

Date

***NOTE: Please sign, Date and return the original document to TRIRIGA REHAB, LLC, LLC*