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#:________-_______-_______Alt/cell:(_____)____________________
Address: _______________________________________, ________________________, ______, ________
Street Address City State Zip

Emergency contact:____ Ph:(_____)_______-__________
Relationship: ☐Spouse ☐Son/Daughter ☐Friend ☐Neighbor ☐Other: ________________

TYPE OF CLAIM:
☐Health Insurance ☐Private Pay ☐Other: _______________________________________

Insurance Information:

Primary Health Insurance:____
Address:____
Phone Number: (_____)________-__________________
Policy Number:__________________________________ Group Number:____________________________
Policy Holders Name:____________________________ Relationship _______________________________

Supplemental Health Insurance:____
Address:____
Phone Number: (_____)________-__________________
Policy Number:__________________________________ Group Number:____________________________
Policy Holders Name:____________________________ Relationship _______________________________

FOR BILLER USE:

VERIFIED ON: _____________________ NO OF VISITS AUTHORIZED: ____________________
PRE-AUTHORIZATION REQUIRED: ☐YES ☐NO AUTHORIZATION PERIOD: __________ TO ___________
COMMENTS:

PAST MEDICAL HISTORY, <u>CHECK ALL THAT APPLY:</u>

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 HAVE RECEIVED 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 healthy 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 to 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 tine, except to the extent that they have taken action in reliance on this consent.

My "Protected Healthy Information" means health information, including my demographic information, collected from me and created or received by my physician, another healthy 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 on at the time of my next appointment.

Name of Establishment: _____________TRIRIGA REHAB, LLC ________________________________

Patient Name: ____

Patient Signature: ____ Date: _____________________

If Personal Representative (Name): ____

Personal Representative Signature: __________________________________ Date: ____________________