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: _____, Email: _____
Street Address

_____, _____, _____
City State Zip

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

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

Insurance Information:

Medicare: _____ Effective Date: _____ (Part A/B)
Contract number

Secondary Health Insurance:_____

Address:_____

Phone Number: (_____)_____-_____

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

Policy Holders Name:_____ Relationship _____

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 _____

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NOTICE OF NOT RECEIVING HOMECARE SERVICES

Patient Name: _____

Date of Birth: _____

Medicare #: _____

I am not currently receiving homecare services through any homecare companies and request that any billing received for home care services from date of _____should be denied as I am only enrolled in out-patient physical therapy under Part B of Medicare. If Medicare should receive any billing for home care services during this time period, it could be that someone is fraudulently using my Medicare number to bill for services never rendered. Please feel free to contact me with any questions at

PH: (___)_____

Signature: _____

Date: _____

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: _____

SOCIAL WORKER SERVICES

Patient Name: _____Telephone: _____

Date Admitted: _____ Age: _____ Diagnosis: _____

We are interested in the total well-being of our patients. In keeping with this philosophy, we feel that social worker intervention may sometimes be appropriate. During your rehabilitation, you, your physician, therapist, or our social worker might agree that this service may be helpful. The social worker is available by appointment to evaluate the social or vocational factors involved in your rehabilitation. To counsel and advise you on social problems arising from your illness or injury and to make appropriate referrals for required services, if any. You may schedule a meeting with our social worker through the receptionist or through your therapist.

Please answer the following questions to assist us in determining whether you might benefit from social work or vocational consulting services.

1. Are you presently out of work because of your illness or injury?
   Yes_____ No_____

2. Are you experiencing stress or related problems because of your illness of injury?
   Yes_____ No_____

3. Are you receiving social work, psychological counseling or vocational counseling through your physician? or insurance company?
   Yes_____ No_____

4. Are you interested in speaking to a social worker?
   Yes_____ No_____

5. Do you live alone?
   Yes_____ No_____

6. Are you your own primary caregiver?
   Yes_____ No_____

7. Are you the primary caregiver for a spouse or family member?
   Yes_____ No_____

8. Do your symptoms prevent you from performing any daily tasks?

Self-care (bathing, washing hair etc)	Yes_____	No_____
Driving	Yes_____	No_____
Grocery shopping	Yes_____	No_____
Preparing food	Yes_____	No_____
Housekeeping	Yes_____	No_____

_____ _____

Patient Signature Date