WELCOME!

PATIENT INFORMATION

Date__________ Soc. Sec.#______________________Birthdate___________________
Name____
Address____________________________________ Phone#______________________
City____________________________________State____________Zip_____________
Sex: Male___Female___ Single___ Married___Divorced___Widow___Separated___
Employer__________________________________Business Phone#________________
Employer Address____
E-Mail Address ____

PRIMARY INSURANCE

Policy Holder Name____
Relationship to Patient______________Soc. Sec.#_______________Birthdate_______
Policy Holder Employer____
Employer Address____
Insurance Co. Name____
Insurance Co. Address_________________________________Group#________________
Insurance I.D. #_________________________________Phone____________________

ADDITIONAL INSURANCE

Policy Holder Name ____
Relationship to Patient_______________Soc. Sec.#______________Birthdate_______
Policy Holder Employer____
Employer Address____
Insurance Co. Name____
Insurance Co. Address__________________________________Group#_____________
Insurance I.D.#__________________________________Phone___________________

ASSIGNMENT and RELEASE

I hereby authorize payment directly to __Trinity Rehab__of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature____Date_____________

TRINITY REHAB LLC

MEDICAL HISTORY QUESTIONNAIRE

Due to your current diagnoses have you had any of the following types of consultations (please check if yes):

___Chiropractor
___Massage Therapist
___Acupuncture
___Physical Therapy
___Occupational Therapy
___MRI/CT Scan
___X-Ray
___EMG
___Nerve Conduction Study
___Emergency Room Care

Have you had surgery in relation to your current diagnoses? ___Yes ___No

If you answered yes: What type of surgery?____________________
When did it take place?___________________
Who was the physician?__________________

Have you ever been diagnosed with any of the following (please check if yes):

___Diabetes
___High Blood Pressure
___Coronary Artery Disease
___Heart Attack
___Shortness of Breath
___Dizziness or Fainting
___Emphysema / COPD
___Cancer
___Osteoporosis
___Arthritis
___Radiation / Chemotherapy
___Unexplained Weight Loss / Energy Loss
___Frequent / Severe Headaches
___Epilepsy / Seizures
___Kidney Disease
___Anemia
___Stroke / TIA
___Hearing / Vision Difficulties
___Bowel / Bladder Problems
___Sleeping Problems
___Emotional / Psych Problems
___Are you Pregnant
___Do you use Tobacco

Please list any medications which you are currently taking:

What is your primary goal during your rehabilitative process?

Patient Signature___________________________________Date____________________

TRINITY REHAB LLC

Union Square Plaza
Office Commons
558 Highway 35 South
Middletown, NJ 07701
Phone: 732-219-5700
Fax: 732-219-5703

Pine Crest Plaza, Bldg 9
1016 Highway 34
Matawan, NJ 07747
Phone: 732-583-0085
Fax: 732-583-0089

Thank you for choosing Trinity Rehab. We are here to serve you, and hope you will find us courteous and caring.

For your benefit and the benefit of our other patients, please comply with the following:

1. Please be prompt to your appointments. If you are more than ten minutes late, without notification, we may not be able to provide treatment until your next scheduled visit.

2. At least 24 hours notice of cancellation is required, except in sudden emergencies. After 3 cancellations, your program may be discontinued and a new prescription will be needed to reschedule. Consistency of treatments is essential for optimal results.

3. If you cancel your appointment without 24 hour notice, a fee of $25.00 will be charged.

Your recovery is of primary importance to us. We appreciate your cooperation.

Thank you,
Trinity Rehab LLC

X___________________________ X________________
Patient signature Date

Trinity Rehab

Reimbursement Policy

Dear Patients,

To complete your therapy sessions successfully, Trinity Rehab takes the responsibility of billing each patient's insurance company. Since each insurance company has different policies, some companies mail our reimbursement checks to the patient. It is vital that these checks be signed over to Trinity Rehab as soon as possible in order for payments to be received. Even though some checks may be made out to the patient, the checks are property of Trinity and failure to comply will result in collections and legal action.

Thank you for your cooperation.

Please sign below to acknowledge the above policy.

X______________________

TRINITY REHAB, LLC - Consent and Acknowledgment of Receipt of Notice of Privacy Practices

Initials:

____**Consent:** I have been informed by my physician of the risks and benefits attendant to the course of treatment and/or therapy (hereinafter "treatment") prescribed by my physician. I understand that it is the opinion of the physician responsible for my care that the benefits of this treatment outweigh the risks of treatment. I fully understand the nature of these risks, including, but not limited to deterioration of my condition, re-injury and/or new injuries. After careful consideration of these risks and benefits, I hereby CONSENT to allow Trinity Rehab, LLC and all personnel employed/contracted by Trinity Rehab, LLC (hereinafter, collectively "Trinity") to perform the treatment and/or therapy specified by my physician, and deemed necessary and/or advisable by Trinity, in accordance with my physician's orders and standards of good clinical practice. I acknowledge that no promises or representations have been made to me regarding the outcome of this treatment. Despite precautions, I understand that Trinity employees may accidentally come into contact with my blood or other bodily fluids as a result of providing the treatment. In case such exposure, I agree that my blood may be tested to determine if I have been exposed to certain infectious diseases. The test results will only be used/disclosed as provided for by law. I agree that the results may be used for the diagnosis and/or treatment of the Trinity employee(s) that were exposed.

____**Assignment of Benefits:** I hereby authorize any insurer or other entity which may have an obligation to provide benefits for this treatment to directly pay same to Trinity. I also understand that I am primarily financially responsible for all costs of my treatment. Understand that some or all of the costs of my treatment may not be allowable or otherwise covered by Medicare or paid by other insurer. As a courtesy to me, Trinity may bill my insurer(s) for the cost of my treatment. Trinity Rehab may choose not accept assignment of benefits; in such case, I am responsible for paying Trinity Rehab directly for sources rendered. In the event that any or all costs of my treatment are denied as non-allowable costs by Medicare, or payment is denied for any reason by any other insurer or agency, I agree to pay the remaining balance of my treatment costs (including any deductibles and/or applicable co-payments) to Trinity within thirty (30) days after I am notified that my insurer has denied any or all benefits for my treatment. Balances unpaid after that time will accrue interest at 1.5% per month or the maximum legal rate. If trinity is required to hire and attorney or collection agency or to file suit to recover any few owed by me, I agree to pay Trinity's collection agency and attorney fees.

____**Valuables:** Trinity does not provide lockers or other secured storage for patients' personal items. I hereby release, save and hold harmless Trinity for any liability with respect to the loss of any personal property or valuables that I choose to keep with me while I am at the Trinity's offices/facilities.

____**Consent to Release Information:** In the event that Trinity requires any of my protected health information for treatment, payment and/or collection purposes, and the holder of such information requires an authorization or release form signed by me as a condition of providing such information to Trinity, I agree to sign such authorization upon Trinity's reasonable request.

____ I have read this form; all of my questions about the contents of this form have been answered to my satisfaction, and I fully understand the contents of this form.

Patient Name:_____________________ Dated:____/____/____

Signature: ________________________ Witness: ______________________

Acknowledgment of Receipt of Notice of Privacy Practices

I have been given a copy of Trinity Rehab's Notice of Privacy Practices ("NPP"). I have had an opportunity to review the NPP and to ask questions regarding the contents of the NPP. My questions about the NPP were answered to my satisfaction.

Patient Name:_____________________ Dated:____/____/____

Signature:________________________ Witness: __________________________