1. Minimize Chance for Exposure

- Mandatory screening questionnaire prior to ALL patient appointments to prevent any high risk patients/staff from entering the office
- Restriction of any patient or staff member that is displaying signs and symptoms consistent with COVID-19 (cough, sore throat, fever) entering the office
- Disinfecting protocol mandating each piece of equipment be disinfected after every patient use as well as every 30' of the entire treatment space
- Mandatory hand sanitizing every 30' for all patients and staff in our treatment spaces

2. Adhere to Standard and Transmission Based Precautions

- Conducting Daily Health Checks and screening of all staff and patients
- Revised Guidelines from CDC for Mask use:
    - **AS PER CDC GUIDANCE, MASKS WILL CONTINUE TO BE REQUIRED IN HEALTHCARE SETTINGS, INCLUDING OFFICE BASED SETTINGS & LONG TERM CARE FACILITIES, CORRECTIONAL FACILITIES, HOMELESS SHELTERS & ON PLANES, BUSES, TRAINS, AND OTHER FORMS OF PUBLIC TRANSPORTATION AS WELL AS TRANSPORTATION HUBS SUCH AS AIRPORTS & STATIONS**
        - NOTE: CDC also states "If you have a condition or are taking medication that weakens your immune system, you may not be fully protected even if you are fully vaccinated.

3. Use of Personal Protective Equipment:

- Trinity Procedures RE: Personal Protective Equipment
    - TRINITY STAFF:
        - ALL Physical Therapists are STILL required to wear N95 Masks
        - ALL staff are STILL required to wear facemasks
    - TRINITY PATIENTS:
        - We continue to require mask use for all patients when in our offices regardless of vaccination status as per CDC guidance

I have read the above and understand the precautions that Trinity Rehab is taking to provide Physical Therapy following CDC guidelines for COVID-19.

_____ _____

Patient/Guardian Signature **Date**

TRINITY REHAB

This disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

Patient Name:_____ **Date:**_____

Please mark "Yes" or "No" to the following questions

UPDATED COVID-19 SCREENING	Date:		Date:		Date:		Date:		Date:	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Do you have a fever or above normal temperature?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you experienced shortness of breath or trouble breathing?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Do you have any of the following: •Dry Cough •Runny Nose •Sore Throat •Reduction or loss of sense of smell	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you tested positive for COVID-19?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you traveled outside of the United States by air or cruiseship in the last 14 days?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you traveled within the United States by air,bus or train within the last 14 days?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you received your COVID-19 vaccine?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
TEMPERATURE:	_____									

UPDATED COVID-19 SCREENING	Date:		Date:		Date:		Date:		Date:	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Do you have a fever or above normal temperature?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you experienced shortness of breath or trouble breathing?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Do you have any of the following: •Dry Cough •Runny Nose •Sore Throat •Reduction or loss of sense of smell	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you tested positive for COVID-19?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you traveled outside of the United States by air or cruiseship in the last 14 days?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you traveled within the United States by air,bus or train within the last 14 days?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you received your COVID-19 vaccine?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
TEMPERATURE:	_____									

TRINITY REHAB

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
___Occupation Therapy
___MRI/CT Scan
___X-Ray
___EMG
___Nerve Conduction Study
___Emergency Room Care

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

Do you have a pacemaker? ___Yes

Are you currently pregnant? ___Yes If yes, how many weeks? _____

Do you have a history of:

Yes	Yes	Yes	Yes
Abnormal Bleeding	Closed Head Injury	Gout	Multiple Sclerosis
Angina	Colitis	Heart Disease	MI/Heart Attack
Anxiety	Congestive Heart Failure	Hepatitis B	Osteoarthritis
Arrhythmia	COPD	Hepatitis C	Osteoporosis
Asthma	CVA (Stroke)	Hiatal Hernia	Psoriatic Arthritis
Bipolar Disorder	Degenerative Disc Disease	High Cholesterol	PVD
Blood Clotting Disorder	Depression	HIV/AIDS	Rheumatoid Arthritis
Bowel Incontinence	Diabetes Type I	Hypertension	Scoliosis
Cancer	Diabetes Type II	Hypothyroidism	Seizure Disorder
Carpal Tunnel Syndrome	DVT	IBS	Shortness of Breath
Cellulitis	Fibromyalgia	Joint Pain	Sleeping Disorder
Chronic Back Pain	Frequent UTI	Lymphedema	TB
Chronic Neck Pain	Gerd	Migraine Headaches	Urinary Incontinence
Crohn's Disease	Glaucoma	MRSA	

Is this injury related to a Motor Vehicle or Worker's Comp. Accident? ___Yes

If yes, please complete the MVA accident form.

What is your primary goal during your rehabilitative process?

_____

_____

_____

Patient Signature_____ Date_____

TRINITY REHAB

MEDICATION LIST

Please list all medications you are currently taking with dosages and frequency OR provide the front desk administrator with a list containing all information below.

Please include all supplements and vitamins.

MEDICATION NAME	DOSAGE	ROUTE (ex. Orally)	FREQUENCY

* If you need additional space, please continue on the back

NO MEDICATIONS: ❑

Height:_____ Weight: _____ Blood Pressure: _____

Patient Signature: _____ Date:_____

We look forward to a successful rehabilitating relationship and thank you for your cooperation

Consent and Acknowledgment of Receipt of Notice of Privacy Practices:

Initials:

_____**Consent**: I have been informed by my physician and/or Physical Therapist of the risks and benefits attendant to the course of treatment and/or therapy (hereinafter "treatment") prescribed by my physician and /or Physical Therapist. I understand that it is the opinion of the physician and /or Physical Therapist 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/or Physical Therapist, and deemed necessary and/or advisable by Trinity, in accordance with my physician's and/or Physical Therapist'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 an 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.

_____**Acknowledgement 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.

_____**Appointment Reminders:** Would you like to receive appointment reminders? **Yes or No**
By selecting yes, I recognize that normal text messaging rates may apply.
Please indicate which method of appointment reminders you prefer ____Text ____Email.
Email/Cellphone number:_____

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 Signature:_____ Date:-_____

TRINITY REHAB

24 Hour Cancellation Policy

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.

Patient Signature:_____ Date:-_____

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

ATTENTION: Medicare Patients

Please be aware of the annual deductible and the 20% patient responsibility when using your Medicare benefits as per Medicare guidelines. If you have a secondary insurance company, we will certainly bill for any patient balance not covered by Medicare. However, in the event of a non-payment from your secondary insurance, you are responsible for the patient balance and will be billed accordingly. If you have Medicaid as your secondary, be aware that Medicaid does not pay for Physical/Occupational Therapy in the state of New Jersey.

In regards to Home Health Care, Medicare does not pay for Out-Patient Physical/Occupational Therapy services while receiving any type of Home Health Care services, including Visiting Nurse services. If you have ever been enrolled in a Home Health Care Program in the past, please make sure your records are updated with Medicare. The dates you have received Home Health Care services cannot conflict with the dates of your Out-Patient Physical/Occupational services in our office. If one of your claims results in non-payment of Medicare because of you receiving Home Health Care services, by law you will be responsible for the balance and will be billed.

I have read the Medicare requirements and acknowledge by my signature:

Patient Signature:_____ Date:-_____

HIPAA – Consent for Release of Personal Information

I give permission to Trinity Rehab to:

Share information regarding my appointment schedule. ***Yes***_____ ***No***_____
Share information regarding my insurance benefits. ***Yes***_____ ***No***_____
If yes, with whom_____

Relation to Patient: _____
Leave detailed voicemail messages regarding my appointment schedule. ***Yes***_____ ***No***_____
Leave detailed voicemail messages regarding my insurance benefits. ***Yes***_____ ***No***_____

If yes, which number(s): Home_____ ***Cell***_____ ***Work***_____

Signature_____Date_____

For BCBS or GHI or MAGNACARE or PIP (AUTO) or UNITED HEALTH CARE Patients:

Reimbursement checks for services rendered by Trinity Rehab, an out of network provider for your plan, may be sent directly to you. These checks will be in your name; however, they are the property of Trinity Rehab as they will be for services rendered, and MUST be handed over to us along with the "Explanation of Benefits". Under no circumstances are you to cash these checks, but you are to sign the back and give to Trinity in person or via mail.

These checks must be surrendered along with the Explanation of Benefits within 7 days of receiving the checks. Failure to do so is considered fraudulent by law and will result in immediate Legal Action and Collection Proceedings.

I_____ acknowledge that while receiving treatment at Trinity Rehab that I may have financial responsibilities. All insurance companies do not pay 100%. PIP (auto) policies may have deductibles and/or co-insurances that the insurance company does not always disclose to the providers.

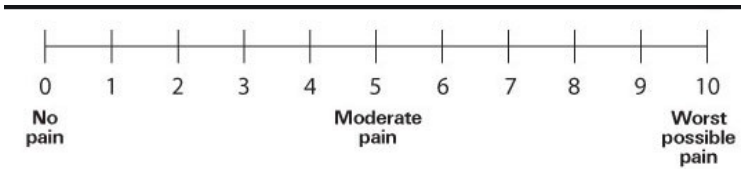
Signature:_____ Date:_____

TRINITY REHAB

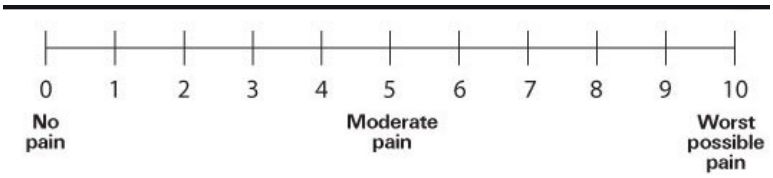
Patient Intake Questionnaire

Patient Name:_____
Date:_____

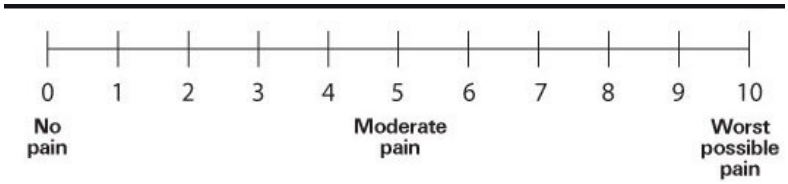
1. Briefly describe your symptoms_____
2. When did your symptoms start?_____
3. How did your symptoms begin?_____
4. How often do you feel your symptoms? Constant____ Frequent____ Occasional____ Intermittent____
5. How would you describe your symptoms? Dull aching___ Sharp___ Stiffness___ Shooting/radiating___ Burning___ Numbness/Tingling___
6. Mark on the scale the following 3 points: **<u>0 being no pain and 10 being the worst pain</u>**
   a. Where you rate the ***AVERAGE*** intensity of your pain:



   b. Where you rate it at its ***BEST:***



   c. Where you rate it at its ***WORST:***



7. How are your symptoms changing? Getting better____Not changing____ Getting worse____
8. Have you had similar symptoms in the past? Yes_____ No_____
9. Who have you previously seen for your symptoms?_____
10. What tests have you taken for your symptoms?_____
11. What is your work status and occupation?_____
12. Name 3 functional activities (examples:walking,bending,lifting,squatting,stairs,grooming,dressing,reaching) that you are limited with due to your symptoms and rate your current ability to perform them. (scale from 0 unable to perform-->10 able to perform at pre injury level)

(1)_____ 0 1 2 3 4 5 6 7 8 9 10

(2)_____ 0 1 2 3 4 5 6 7 8 9 10

(3)_____ 0 1 2 3 4 5 6 7 8 9 10

TRINITY REHAB

Patient Health Questionnaire (PHQ-9)

Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down,depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep,or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3
COLUMN TOTALS				
ADD COLUMN TOTALS HERE FOR TOTAL SCORE				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult At All	
	Somewhat Difficult	
	Very Difficult	
	Extremely Difficult	

TRINITY REHAB

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO APPEAL AND/OR COLLECT BENEFITS

Patient Name:_____

Date of Birth:_____

Insurance Company:_____

I am the "Patient" and I hereby authorize, direct, and consent to the following in consideration of the services rendered by the "Provider" _____.

1) An assignment of the right to bill, collect, appeal, litigate and/or arbitrate claims for any applicable insurance benefits to the Provider, including but not limited to treatments, supplies, and any other related fees to which the Patient may be entitled for services rendered by the provider.

2) The authorization for the Provider to act as my agent-in-fact with regard to all aspects regarding a claim and to receive any-and-all documents, and/or communications regarding the claim and any appeals of a denial of the claim.

3) Authorization to the Provider to initiate and prosecute any-and-all appeals and/or arbitrations or legal actions, including but not limited to internal appeals and No-Fault PIP Arbitrations.

4) The authorization for the Provider to obtain and/or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization.

5) The authorization for payment of any and all insurance benefits, including No-Fault PIP benefits, directly to the Provider to which the Patient is entitled under the policy of insurance.

6) The Patient agrees to fully cooperate with the Provider's efforts to prosecute a claim for insurance benefits if timely payment of medical expense benefits is not made to the Provider for services rendered.

Patient Signature:_____ **Date:**_____