Trinity Wellness Center

New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

Account # Social Security # Tule Last Name First Name MI Street Address (Road or Street) (Apartment Number or Second Address Line) ////////////////////////////////////					P	atient	Info	rmation		1.1 MA	
Zip Code City State Home Phone: Cell Phone: Email Address: Patient Data: (Nick Name) Birthday Sex (M, F) Referring Doctor full name Reason for Referral Marical Marine Employment Student P.Fatt Student Birthday Sex (M, F) Referring Doctor full name Reason for Referral Marine D-Divorced X-Separated P.Part N-None D'Fort D'Fort </td <td>Account #</td> <td>Social Secur</td> <td>ity #</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>t Name</td> <td>MI</td>	Account #	Social Secur	ity #							t Name	MI
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							I authorize payment of medical benefits directly to this practice for the services rendered.				
Signed Date Signed Date	Signed					Date	Sig	gned		Date	

200 Horizon Drive, Suite 115, Raleigh, NC 27615 Phone: 919-875-1932 • Fax: 919-875-1933 E-mail: admin@trinitywellnesscenter.net

CANCELLATION/NO SHOW POLICY

Patient/Guardian:

DOB:

Twenty-four hour notice of a cancellation is requested so that other patients needing services may be notified in time to fill any available slots. In the case of an unexpected change of schedule, please call and notify us of need to cancel as soon as possible. Recurrent late cancellations or no-show appointments will be subject to a **\$40 fee.** In the event of multiple occurrences of this, Trinity Wellness Center reserves the right to discontinue services.

We are committed to providing high-quality services and are dedicated to providing you a one-on-one appointment each time you come in. Because of this commitment, we kindly ask that you respect our time and the needs of other patients by cooperating with this policy.

The undersigned acknowledges the Trinity Wellness Center cancellation/no show policy and understands that a \$40 fee will be imposed when appointments are missed without prior notice.

I acknowledge that in the event of multiple occurrences of this, Trinity Wellness Center reserves the right to discontinue providing services.

Signature of Patient/Guardian:	Date:	
U		



Financial Policy and Admission Agreement Certification of Receipt of Notice of Privacy Practices

Consent for Services:

I hereby authorize the staff of Trinity Wellness Center to administer physical therapy services as ordered by my physician (physician's orders not necessary for self-pay patients) and as described in my plan of care.

Consent for Services for Minor:

I hereby authorize the staff of Trinity Wellness Center to administer physical therapy services as ordered by the ordering physician (physician's orders not necessary for self-pay patients) and as described in the plan of care. I understand that minors over age 16 do not require my presence and I authorize Trinity Wellness Center to administer physical therapy services without my being present.

Assignment of Benefits:

I certify that the information given by me in applying for payment from my insurer is correct. I request that payment of authorized benefits be made on my behalf to Trinity Wellness Center, Inc. I understand that I am fully responsible to Trinity Wellness Center for all charges not paid by my insurer within 60 days.

Notice of Privacy Practices:

I acknowledge receipt of a copy of the Trinity Wellness Center Notice of Privacy Practices and understand how my protected health Information may be used and disclosed by this office. I understand my rights as a patient and authorize Trinity Wellness Center to disclose my protected health information as explained in this notice.

Furthermore, I hereby authorize the below designated parties (spouse, family member, etc.) to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to my treatment. I understand that the identity of designated parties must be verified before the release of any information.

The undersigned acknowledges receipt of the Trinity Wellness Center Financial Policy and Admission Agreement; and understands the patient rights and responsibilities. The undersigned agrees to the policies above regarding payment; and agrees that if this account becomes delinquent and requires collection service, all reasonable collection and handling charges will be added to the outstanding balance after 30 days.

Patient Name (Please Print):				
Guardian Name/Signature (if patient is minor):				
I would like to receive appointment reminder message	es via (Please Circle)	Email	Text	Both
I give permission to leave messages on voicemail (Pl	ease Circle) Yes	No		
I give permission to discuss medical condition, appoir	atments or account with	n below de	signated p	people:
Emergency Contact:	Relationship:	Pho	one	a
Authorized Designee:	Relationship:	Pho	one	
Signature of Patient/Guardian:		_Date:		
Witness:		_ Date:		

Medical History

Existing or Relevant Previous Conditions

Allergies	⊖Yes ⊖No	Dizzy Spells	⊖Yes ⊖No	MRSA	🔿 Yes 🔿 No
Anemia	OYes ONo	Emphysema/Bronchitis	⊖Yes ⊖No	Multiple Sclerosis	O Yes O No
Anxiety	⊖Yes ⊖No	Fibromyalgia	OYes ONo	Muscular Disease	OYes ONo
Arthritis	O Yes O No	Fractures	⊖Yes ⊖No	Osteoporosis	🔿 Yes 🔿 No
Asthma	⊖Yes ⊖No	Gallbladder Problems	OYes ONo	Parkinsons	⊖ Yes ⊖ No
Autoimmune Disorder	⊖Yes ⊖No	Headaches	O Yes O No	Rheumatoid Arthritis	⊖ Yes ⊖ No
Cancer	⊖Yes ⊖No	Hearing Impairment	Yes No	Seizures	🔿 Yes 🔿 No
Cardiac Conditions	⊖Yes ⊖No	Hepatitis	OYes ONo	Smoking	⊖Yes ⊖No
Cardiac Pacemaker	OYes ONo	High Cholesterol	O Yes O No	Speech Problems	🔿 Yes 🔿 No
Chemical Dependency	⊖Yes ⊖No	High/Low Blood Pressure	O Yes O No	Strokes	O Yes O No
Circulation Problems	OYes ONo	HIV/AIDS	O Yes O No	Thyroid Disease	O Yes O No
Currently Pregnant	⊖Yes ⊖No	Incontinence	OYes ONo	Tuberculosis	⊖ Yes ⊖ No
Depression	⊖Yes ⊖No	Kidney Problems	OYes ONo	Vision Problems	🔾 Yes 🔾 No
Diabetes	⊖ Yes ⊖ No	Metal Implants	Yes No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? () Yes () No Two or more falls in the last year? () Yes () No Patient is at risk for falls? () Yes () No

Surgical History

Body Region:		Surgery Type:		Date:	ا	_
Body Region:		Surgery Type:		Date:		-
Body Region:		Surgery Type:		Date:		_
Body Region:		Surgery Type:		Date:		-
Current Medic	cations					
Drug:	Dosage:	Frequency:	Route:	Reason Taking:		_
Drug:	Dosage:	Frequency:	Route:	Reason Taking:	9.84±1.	_
Drug:	Dosage:	Frequency:	Route:	Reason Taking:		_
Drug:	Dosage:	Frequency:	Route:	Reason Taking:		_

Currently not taking any medications