



Table of Contents: First Session Forms

This packet contains 5 documents that the participant must complete and turn back into the Class Leader.

02 Registration Form

Required upon initial registration.

Registration should be updated when there is a change in address, contact information, or insurance information.

03 Pre-Survey Questions

Required at the beginning of every class.

06 Release and Waiver of Liability Agreement

Required annually for class participation.

Acknowledges and agrees to the terms listed on the agreement. Participant accepts certain risk and waives the right to take legal action against Juniper. Participant must receive this document and sign their agreement once every 12 months.

07 Insurance Authorization and Release of Information

Required annually for class participation.

Authorizes Juniper to bill health insurance company if Juniper is a covered benefit. Participant must receive this document and sign their agreement once every 12 months.

08 Acknowledgement of Receipt of Notice of Privacy Practices

Required upon initial registration.

Describes all ways Juniper gathers, uses, and discloses information, data security, and user choices about personal information. Participant must receive this document and sign their agreement once.



Registration Form

By completing the fields below, you will be registered for this class on www.yourjuniper.org.

***Denotes required information**

* First Name: _____

* Last Name: _____

* Email Address: _____

* Phone: _____ * Date of Birth: MM DD YYYY

* Address: _____

* City: _____ * State: _____ * Zip: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Please select your health system.

- | | | |
|---|--|--|
| <input type="checkbox"/> Allina Health | <input type="checkbox"/> Lake Region Healthcare | <input type="checkbox"/> Other (please specify)
_____ |
| <input type="checkbox"/> Bluestone Physicians | <input type="checkbox"/> M Health Fairview | |
| <input type="checkbox"/> CentraCare Health | <input type="checkbox"/> Mayo Clinic | |
| <input type="checkbox"/> Essentia Health | <input type="checkbox"/> North Memorial Health | |
| <input type="checkbox"/> HealthPartners/Park Nicollet | <input type="checkbox"/> Riverwood Healthcare Center | |
| <input type="checkbox"/> Herself Health | <input type="checkbox"/> Sanford Health | |

Health Insurance Information:

* Health Insurance Provider: _____

* Group ID: _____ * Member ID: _____

Juniper® programs are offered as a covered benefit by some of Minnesota's health insurance plans. By listing the health plan name, group ID, and member ID, Juniper will be able to verify whether the participant is an eligible member with this covered benefit.

The participant's protected health information will be generated during their participation and their privacy will be protected as required by all applicable laws.



*** How did you hear about this program?**

- Juniper Website
- Doctor or Healthcare Provider
- Flourish Email Newsletter
- Family or Friend
- Social Media (e.g. Facebook or Twitter)
- Flyer or other print material
- Health Insurance Provider/Care Coordinator
- Other (please specify) _____

Do you require any special accommodations? Yes No

If yes, please specify your accommodations: _____



Live Well Pre-Survey Questions

Participant name: _____

Participant's date of birth (MM / DD / YY): _____

Participant number (if known): _____

Provider name (e.g. XYZ Organization): _____

Program name: _____

Today's Date (MM / DD / YY): _____

1. Did your doctor or other health care provider suggest that you attend this program?

Yes No

2. How old are you today? _____ years

3. Do you live alone? Yes No

4. Are you Hispanic, Latino, or of Spanish origin? Yes No

6. What is your race? Check all that apply.

American Indian or Alaska Native Asian

Black or African American White

Native Hawaiian or other Pacific Islander

Other (please specify) _____

7. What is your current gender (select one)?

Man Woman Non-binary _____ (please specify)

Prefer not to answer

8. Do you consider yourself to be transgender? Yes No Prefer not to answer



9. Which of the following best represents how you think of yourself (select one)?

- Lesbian or gay
- Straight, that is, not gay or lesbian
- Bisexual
- Two-Spirit
- I use a different term (please specify): _____
- I don't know
- Prefer not to answer

10. What is the highest grade or year of school you completed?

- Some elementary, middle or high school
- High school graduate or GED
- Some college or technical school
- College (4 years or more)

11. Have you ever served in the military?

- Yes
- No

12. During the past year, did you provide regular care of assistance to a friend or family member who has a long-term health problem or disability?

- Yes
- No

13. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

14. Has a healthcare provider ever told you that you have any of the following chronic conditions? (i.e. one that has lasted for three months or more)

Check all that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Alzheimer's Disease or Other Dementia | <input type="checkbox"/> Cancer or cancer survivor | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Schizophrenia or other Psychotic Disorder |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis/Rheumatic Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Substance Use Disorder |
| <input type="checkbox"/> Asthma/Emphysema/ Other Chronic Breathing or Lung Problem | <input type="checkbox"/> Diabetes (High Blood Sugar) | <input type="checkbox"/> Obesity | <input type="checkbox"/> Urinary Incontinence |
| | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Osteoporosis (low bone density) | <input type="checkbox"/> Other Chronic Condition |
| | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Post-Traumatic Stress Disorder | |

15. Please answer yes or no for the following questions.

	Yes	No
a. Are you deaf or do you have serious difficulty hearing?		
b. Are you blind or do you have serious difficulty seeing, even when wearing glasses?		
c. Do you have serious difficulty walking or climbing stairs?		
d. Do you have difficulty dressing or bathing?		
e. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?		
f. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?		

16. How often do you feel lonely?

- Always
 Often
 Sometimes
 Rarely
 Never

17. How often do you feel isolated from those around you?

- Always
 Often
 Sometimes
 Rarely
 Never

18. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure	0	1	2	3	4	5	6	7	8	9	10	Totally sure
-------------------	---	---	---	---	---	---	---	---	---	---	----	-----------------



Release and Waiver of Liability Agreement

As a participant in this class, the undersigned agrees to indemnify and release and hold harmless Innovations for Aging, LLC, its directors, officers, employees, and agents from any loss, liability, injury, illness from infectious disease including COVID-19, cost, or damage they may incur resulting from such class participation.

In addition, by signing, the undersigned agrees:

- Information provided in the class does not replace the advice of medical professionals;
- To address concerns with the undersigned's medical provider if the undersigned believes the information in the class conflicts with the advice of the undersigned's medical provider;
- The undersigned has been informed that the sessions may include light to moderate exercise including stretching, balance, and range of motion exercises;
- The undersigned assumes full responsibility for and risk of bodily injury, death, or property damage due to negligence or releases or otherwise while participating in any class affiliated with Innovations for Aging, LLC; and
- To work within their own comfort zone and agrees to stop participating if they feel any pain or discomfort and will let one of the class instructors know about their condition or concerns.

Participant's Printed Name: _____

Participant Signature: _____

Date: _____



Insurance Authorization and Release of Information

Insurance and Payment Authorization:

Juniper® programs are offered as a covered benefit by some health insurance plans. By listing the health plan name, group ID, and member ID, Juniper will be able to verify whether the participant is an eligible member with this covered benefit.

Payment Responsibility. I agree to pay for all services furnished to me by Innovations for Aging, LLC d/b/a Trellis and the Juniper® programs (collectively, “Juniper”) that are not paid in full by my insurance, government program benefits or other third-party payors, upon receipt of a statement, except as prohibited by Juniper’s contract with my health plan or applicable law.

Payment Authorization. I authorize Juniper to directly bill my health plan or third-party payor for services rendered to me by or on behalf of Juniper but acknowledge that Juniper is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to Juniper for such services. I understand I am financially responsible to Juniper for charges not covered by my insurance, government program benefits or other third-party payors.

Release of Information:

I also authorize Juniper to use my personal information (including health information) and/or records about me to the extent permitted by law and to disclose such information to: (i) health care or social service providers or other persons involved in my care; (ii) health plans, insurers, or other third party payors for the purpose of claims administration, benefit determinations, benefit development, or quality initiatives; and (iii) persons or organizations in connection with Juniper’s health care operations and business management. I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

Participant’s Printed Name: _____

Participant Signature: _____

Date: _____



Acknowledgement of Receipt of Notice of Privacy Practices

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Trellis Notice of Privacy Practices. Trellis is permitted to revise their Notice of Privacy Practices at any time. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

By signing below, you are acknowledging that you have received a copy of the Notice of Privacy Practices.

Patient Name (printed): _____

Signature: _____ **Date:** _____

Patient Representative, if applicable: _____

If signed by Patient Representative, state authority to act on behalf of patient:

Entity Use Only

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement not obtained: _____

Signature: _____ **Date:** _____