



## 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.*

### **04 Pre-Survey Questions**

Required at the beginning of every class.

### **08 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 complete the signature at each class registration.*

### **09 Insurance Authorization and Release of Information**

Required annually for class participation.

*Authorizes Juniper to bill health insurance company. Participant must receive these documents and complete the signature at each class registration.*

### **10 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 complete the signature parts once.*



## Registration Form

By completing the fields below, you will be registered for this class on [www.yourjuniper.org](http://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)<br>_____ |
| <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?**

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

Do you require any special accommodations?  Yes  No

If yes, please specify your accommodations: \_\_\_\_\_

\_\_\_\_\_



## Falls Prevention Pre-Survey Questions

Participant's Name: \_\_\_\_\_

Participant's Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Participant Number (if known): \_\_\_\_\_

Provider Name (e.g. XYZ Organization): \_\_\_\_\_

Program Name: \_\_\_\_\_

Today's Date (MM/DD/YYYY): \_\_\_\_\_

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

- Yes       No

2. From what health system do you receive your primary healthcare services?

- |   |  |
|---|--|
| <input type="checkbox"/> Allina Health            | <input type="checkbox"/> Lake Region Health Care               |
| <input type="checkbox"/> Carris Health            | <input type="checkbox"/> Mayo Clinic                           |
| <input type="checkbox"/> CentraCare               | <input type="checkbox"/> North Memorial Health                 |
| <input type="checkbox"/> Essentia Health          | <input type="checkbox"/> Sanford Health                        |
| <input type="checkbox"/> Fairview Health Services | <input type="checkbox"/> St. Luke's Regional Healthcare System |
| <input type="checkbox"/> Gunderson Health System  | <input type="checkbox"/> University of Minnesota Physicians    |
| <input type="checkbox"/> HealthPartners           | <input type="checkbox"/> Other                                 |
| <input type="checkbox"/> Hennepin Health          | <input type="checkbox"/> I don't know                          |

3. What is your current age? \_\_\_\_\_

4. Do you live alone?       Yes       No

5. Are you:     Male       Female       Other

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

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

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American | <input type="checkbox"/> Native Hawaiian or other Pacific Islander<br><input type="checkbox"/> White |
|---|--|

8. What is your highest level of education?

- |  |  |
|--|--|
| <input type="checkbox"/> Some elementary, middle or high school<br><input type="checkbox"/> Some college or technical school | <input type="checkbox"/> High school graduate or GED<br><input type="checkbox"/> College (4 years or more) |
|--|--|

9. 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<br><input type="checkbox"/> Anxiety Disorder<br><input type="checkbox"/> Asthma/ Emphysema/ Other Chronic Breathing or Lung Problem<br><input type="checkbox"/> Cancer or cancer survivor<br><input type="checkbox"/> Chronic pain<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Diabetes (High Blood Sugar)<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> High cholesterol<br><input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Kidney disease<br><input type="checkbox"/> Obesity<br><input type="checkbox"/> Osteoporosis (low bone density)<br><input type="checkbox"/> Schizophrenia or other Psychotic Disorder<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Arthritis/Rheumatic Disease<br><input type="checkbox"/> Other Chronic Condition<br><input type="checkbox"/> Parkinson’s Disease<br><input type="checkbox"/> Traumatic Brain Injury<br><input type="checkbox"/> Urinary Incontinence |
|--|--|

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

- Excellent     
  Very good     
  Good     
  Fair     
  Poor

11. How often do you feel lonely or isolated from those around you?

- Never     
  Rarely     
  Sometimes     
  Often     
  Always

**These next few questions are about falls. By fall, we mean when a person unintentionally comes to rest on the ground or another lower level.**

12. In the past 3 months, how many times have you fallen? \_\_\_\_\_ (times)

If you have fallen since this program began -

12A. How many of these falls caused an injury? \_\_\_\_\_

*(An injury means the fall caused you to limit your regular activities for at least a day, or resulted in a visit to a doctor.)*

12B. Did you tell anyone, such as a family member, friend or healthcare provider about this fall (whether or not it resulted in an injury?)

Yes       No

12C. What happened after you fell? (Check all that apply)

Went to the emergency room       Was admitted to the hospital  
 Visited primary Care physician       Did not seek medical care

13. How fearful are you of falling?

Not at all       A little       Somewhat       A lot

14. During the last 4 weeks, to what extent has your concern about falling interfered with your normal social activities?

Not at all     Slightly     Moderately     Quite a bit     Extremely

15. How sure are you that you can do the following activities: (Check one response only)

15A. I can find a way to get up if I fall

Not at all     Somewhat sure     Neutral     Sure     Very Sure

15B. I can find a way to reduce falls

Not at all     Somewhat sure     Neutral     Sure     Very Sure

15C. I can increase my flexibility

Not at all     Somewhat sure     Neutral     Sure     Very Sure

15D. I can increase my physical strength

Not at all     Somewhat sure     Neutral     Sure     Very Sure



15E. I can become more steady on my feet

- Not at all     Somewhat sure     Neutral     Sure     Very Sure

16. What best describes your activity level

- Vigorously active for at least 30 minutes, 3 times per week  
 Moderately active for at least 30 minutes, 3 times per week  
 Seldom active, preferring sedentary activities



## 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:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient Representative, if applicable: \_\_\_\_\_

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

\_\_\_\_\_

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### 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:** \_\_\_\_\_