JUNIPER®
Your Health. Your Community.
A Program of TRELLIS™

Table of Contents: First Session Forms

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

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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.

☐ Allina Health
☐ Bluestone Physicians
☐ CentraCare Health
☐ Essentia Health
☐ HealthPartners/Park Nicollet
☐ Herself Health
☐ Lake Region Healthcare
☐ M Health Fairview
☐ Mayo Clinic
☐ North Memorial Health
☐ Riverwood Healthcare Center
☐ Sandford Health
☐ Other (please specify) _____

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
☐ Social Media (e.g. Facebook or Twitter)
☐ Doctor or Healthcare Provider
☐ Flyer or other print material
☐ Flourish Email Newsletter
☐ Health Insurance Provider/Care Coordinator
☐ Family or Friend
☐ 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/YYY): _____

Participant Number (if known): _____

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

Program Name: _____

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

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?
   - ☐ Allina Health
   - ☐ Carris Health
   - ☐ CentraCare
   - ☐ Essentia Health
   - ☐ Fairview Health Services
   - ☐ Gunderson Health System
   - ☐ HealthPartners
   - ☐ Hennepin Health
   - ☐ Lake Region Health Care
   - ☐ Mayo Clinic
   - ☐ North Memorial Health
   - ☐ Sanford Health
   - ☐ St. Luke's Regional Healthcare System
   - ☐ University of Minnesota Physicians
   - ☐ Other
   - ☐ 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.

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or other Pacific Islander

☐ White

8. What is your highest level of education?

☐ Some elementary, middle or high school ☐ High school graduate or GED

☐ Some college or technical school ☐ 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:

☐ Alzheimer's Disease or other dementia

☐ Anxiety Disorder

☐ Asthma/ Emphysema/ Other Chronic Breathing or Lung Problem

☐ Cancer or cancer survivor

☐ Chronic pain

☐ Depression

☐ Diabetes (High Blood Sugar)

☐ Heart disease

☐ High cholesterol

☐ Hypertension (high blood pressure)

☐ Kidney disease

☐ Obesity

☐ Osteoporosis (low bone density)

☐ Schizophrenia or other Psychotic Disorder

☐ Stroke

☐ Arthritis/Rheumatic Disease

☐ Other Chronic Condition

☐ Parkinson's Disease

☐ Traumatic Brain Injury

☐ 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 as about falls. By fall, we mean when a person unintentionally comes to rest on the ground or another lower lever.

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 undersignedbelieves the information in the class conflicts with the advice of the undersigned'smedical provider;
- The undersigned has been informed that the sessions may include light to moderateexercise including stretching, balance, and range of motion exercises;
- The undersigned assumes full responsibility for and risk of bodily injury, death, orproperty damage due to negligence or releasees or otherwise while participating in anyclass affiliated with Innovations for Aging, LLC; and
- To work within their own comfort zone and agrees to stop participating if they feel anypain 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: _____

Patient Representative: _____

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

_____

Signature: _____ Date: _____

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: _____