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.

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*** 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: _____

_____

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Diabetes Prevention Program Pre-Survey Questions

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

First Name: _____

Last Name: _____

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

1. Who or what motivated you the most to sign up for this National Diabetes Prevention lifestyle change program? (check one)

   ☐ Healthcare professional

   ☐ Blood test result

   ☐ CDC prediabetes risk test

   ☐ Someone at a community-based organization (church, community center, fitness center, etc.)

   ☐ Current or past participant in the National DPP Lifestyle Change Program

   ☐ Employer or employer's wellness plan

   ☐ Health insurance plan

   ☐ Media advertisements (social media, flyer, brochure, radio ad, billboard, etc.)

   ☐ Other _____

2. Did your doctor or other healthcare provider suggest that you to join this program?

   ☐ Yes, a doctor/doctor's office ☐ Yes, a pharmacist

   ☐ Yes, other healthcare professional ☐ No

3. Who is the primary payer for your participation in this National Diabetes Prevention Lifestyle Change Program?

   ☐ Medicare ☐ Medicaid ☐ Private insurer ☐ Self-pay

   ☐ Dual-eligible (Medicare and Medicaid) ☐ Medicaid ☐ Grant funding

   ☐ Employer ☐ Free of charge ☐ Other _____

4. Within the past year, have you received a diagnosis of pre-diabetes by your blood glucose (HbA1c) levels ranging between 5.7% - 6.4%?

   ☐ Yes - what is your HbA1c level? _____

   ☐ No

5. Within the past year, have you received a diagnosis of pre-diabetes by your fasting blood glucose levels from the Fasting Plasma Glucose (FPG) test ranging between 100-125 mg/dL?

   ☐ Yes - what is your Fasting Plasma Glucose level? _____

   ☐ No

6. Within the past year, have you received a diagnosis of pre-diabetes by your blood glucose levels from the Oral Glucose Tolerance Test (OGTT) ranging between 140-199 mg/dL?

   ☐ Yes - what is your Oral Glucose Tolerance Test level? _____

   ☐ No

7. Have you ever been told by a health care provider that you had Gestational Diabetes Mellitus (GDM) during pregnancy?

   ☐ Yes ☐ No ☐ N/A

8. Are you at risk for having pre-diabetes from your results on the *Prediabetes Risk Test*?

   ☐ Yes ☐ No

9. Have you been diagnosed with Type 1 or Type 2 Diabetes?

   ☐ Yes ☐ No

10. Have you been diagnosed with End-Stage Renal Disease (ESRD)?

    ☐ Yes ☐ No

11. What is the ethnicity with which you identify? (check one)

    ☐ Hispanic or Latino ☐ Not Hispanic or Latino

12. What is the race with which you identify? (check all that apply)

    ☐ American Indian or Alaska Native ☐ Asian or Asian American

    ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander

    ☐ White

13. What sex were you assigned at birth?

☐ Male ☐ Female

14. How do you describe your gender identity?

☐ Male ☐ Female ☐ Transgender ☐ Prefer not to answer

15. How tall are you? _____ feet _____ inches

16. How much do you weigh? _____ pounds

17. What is the highest grade or level of school that you completed?

☐ Less than grade 12 (No high school diploma or GED)

☐ Grade 12 or GED (High school graduate)

☐ Some college or technical school

☐ College or technical school graduate or higher

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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: _____

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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: _____

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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: _____