Centro de servicios de rehabilitación para pacientes ambulatorios de George Washington University (GWU)
2131 K St. NW | Suite 620 | Washington, DC 20037 | Tel.: (202) 715-5655 | Fax: (202) 715-5664

¡Bienvenido a nuestro consultorio!

Lea este documento para interiorizarse de algunas políticas importantes y saber qué debe esperar una parte de la otra.

Qué debe saber

- Puede llamar en cualquier momento al 202-715-5655 y presionar la opción 2 para pedir, cambiar o cancelar una cita.
- Las citas duran, generalmente, de 30 a 60 minutos.
- Necesitará **una receta emitida** por su médico a efectos de aseguramiento.
- Si pasaron más de 30 días desde la última consulta, es posible que necesite una nueva receta. Consulte con su terapeuta.

Política de cancelación o de no concurrencia

La asistencia es muy importante para su progreso

- Si tiene que cancelar la cita, llame al 202-715-5655 (opción 2) con 24 horas de anticipación.
- Consideramos que un aviso de menos de 24 horas significa que no va a concurrir y nuestra política funciona de la siguiente manera:

¿Qué ocurre si no se presenta una vez? ¡No se preocupe, podría pasarle a cualquiera!

Si no se presenta por segunda vez consecutiva

O

por tercera vez en un periodo de 30 días:

Se le inhabilitará el ingreso a la terapia; no podrá regresar.

¿Se le hizo tarde? Haremos lo que esté a nuestro alcance, ¡pero es posible que no podamos atenderlo después de 15 minutos!

Seguro

- Asegúrese de revisar los beneficios que le proporciona el seguro. Queremos evitar que reciba facturas inesperadas.
- Si tiene dudas con respecto a las facturas, llame al 202-715-4905.

Certificación: al firmar este documento, confirmo que comprendo estas políticas. Gracias.

Firma _____ Fecha _____

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

Documento informativo y de asistencia a los servicios de rehabilitación para pacientes ambulatorios con la firma del paciente

Etiqueta del paciente

CO4000

DOB: SX:
MRN:

Treatment Authorization

s the individual who will be receiving services at George Washington University Hospital
ne "Hospital"), or the parent or guardian of the individual listed below as the patient, I agree to
ie following terms and conditions of this Treatment Authorization Agreement (the "Agreement"). As
pplicable, I further agree that the terms and conditions of this Agreement apply to any newborn
ifant(s) I deliver while I am a patient in the Hospital.

Consent to Hospital Procedures

- I consent to medical and surgical procedures that might be performed during this hospitalization or outpatient visit, including emergency treatment or services for the patient. These services may include but are not limited to laboratory tests, X-rays, medical or surgical treatment or procedures, anesthesia, and hospital services rendered to me under the general and special instructions of the attending Physician or Surgeon.
- I hereby authorize the "Hospital" to recognize my attending Physician as the manager of my medical and/or surgical care and treatment. I consent to and authorize my attending Physician and/or his/her designee, to administer treatment (medical, surgical, anesthetic, obstetrical and/or any other therapeutic or diagnostic procedure) that he/she/they may dictate as advisable for my wellbeing. I understand that video or telephone consultation/evaluation may be used as a part of my care or treatment. I understand that the "Hospital" will provide medical and insurance information to my designated primary care Provider and/or referred healthcare Providers for the purpose of continuing care.
- I understand that the "Hospital" may have affiliations with a variety of health care related educational programs. These programs may include but are not limited to: Nursing, Medical, EMT, Surgical Technician and Physical Medicine. I consent to have students participate in my care under the supervision of their instructor(s) and understand that I must express any refusal to have them participate to a management representative such as Charge Nurse, Nurse Manager, shift Manager, department Director, Senior Manager, etc.
- The nature of the operation/treatment has been explained to me. I am aware that the practice of medicine and surgery is not an exact science. *No* warranty or guarantee has been made to me as to a cure or the treatment's result.
- I authorize the "Hospital" to retain, preserve, and to use for scientific or teaching purposes, and properly dispose of any specimen or tissue removed from my body during this hospitalization or outpatient visit.
- I understand that pictures may be taken of my medical/surgical condition or treatment. I understand that pictures might be used for purposes of my diagnosis, treatment, or for educational training programs conducted by the hospital. These pictures will be part of the documentation in my medical record.

Special Consent for HIV Testing and Other Blood Borne Pathogens

I understand that this consent form covers testing for blood borne infectious diseases, including but not limited to hepatitis, acquired immune deficiency syndrome (AIDS), and human immunodeficiency virus (HIV). A physician may order such test(s) for diagnostic purposes to determine the appropriate treatment and/or treatment procedures for me or to protect the attending Physician and/or any employee or agent of the "Hospital" exposed to my bodily fluids in a manner which could transmit such disease.

Non Smoking Campus

I understand that smoking is not permitted on the campus of the "Hospital", except in designated areas, and I agree to comply accordingly.

Treatment Authorization

Patient Identification

CO0058

UHS-9011(SMS)
Rev. 02/2019

hysician Providers Are Not Hospital Employees

acknowledge and agree that the "Hospital" is not responsible for the judgment or conduct of any hysician who treats or provides a professional service to me, but rather each Physician is an ıdependent contractor who is not the agent, servant, or employee of the hospital. The "Hospital" or ffiliate agency is not liable for any acts or omission made by any Physician or in following the order of he Physician.

'ersonal Valuables

understand that the "Hospital" maintains a safe for the safekeeping of money and other valuables, and ıat the "Hospital" is not liable for the loss of my valuables unless they are deposited with the "Hospital" ɔr safekeeping. I understand that I am responsible for all my personal effects not deposited in the safe, ıcluding, but not limited to, personal grooming articles, jewelry, clothing, documents, medications, eye ılasses, hearing aids, dentures and other prosthetic devices.

;ignatures - Please read before signing

This is to certify that I, the undersigned, being the patient, or another person legally authorized to act for he patient, have carefully read and fully understand this treatment authorization and am duly authorized o execute the above and accept its terms.

The undersigned acknowledges having read and received a copy of this document. A copy of this ıuthorization shall be as valid as the original.

Patient/Authorized Signature _____ Date/Time _____

Witness Signature _____ 2nd Witness Signature for Verbal Consent _____

Treatment Authorization

Patient Identification

CO0058

UHS-9011(SMS)
Rev. 02/2019

Assignment of Benefits and Financial Responsibility

As the individual who will be receiving services at George Washington University Hospital (the "Hospital"), or the parent or guardian of the individual listed below as the patient, I agree to the following terms and conditions of this Assignment of Benefits and Financial Responsibility Agreement (the "Agreement"). As applicable, I further agree that the terms and conditions of this Agreement apply to any newborn infant(s) I deliver while I am a patient in the Hospital.

Irrevocable Assignment of Benefits and Right of Action

For good and valuable consideration, I make the following irrevocable assignments to the "Hospital".

- **Assignment of Health Insurance Benefits:** I irrevocably assign to the "Hospital" all benefits for services rendered by the hospital, payable by a health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity responsible for payment of the patient's total hospital bill. This assignment extends to the amount of the patient's total hospital bill(s), with interest as allowed by law. I authorize and expressly direct such entity to pay benefits directly to the "Hospital". I also authorize and instruct any such entity to assign and pay directly to physician groups providing hospital based services such as Pathology, Radiology, Anesthesiology, Cardiology and Emergency Physician Services, any insurance benefits due them.

- **Assignment of Personal Injury Proceeds:** I irrevocably assign and transfer to the "Hospital" all benefits for services rendered to the patient by the hospital payable under Personal Injury Protection, Medical Pay, Uninsured/Underinsured, and/or Liability provisions of any insurance policy under which patient is entitled to benefits as the result of an occurrence causing the patient's injuries and treatment. I agree this assignment extends to the amount of the patient's total hospital bill(s), with interest as allowed by law. I authorize and expressly direct the insurance company to pay benefits directly to the "Hospital". I also authorize and instruct any such entity to assign and pay directly to physician groups providing hospital based services such as Pathology, Radiology, Anesthesiology, Cardiology and Emergency Physician Services, any insurance benefits due them.

- **Assignment of Claims and Right of Action:** I irrevocably assign and transfer to the "Hospital" all patient's rights, title and interest in any claim(s) patient may have against any third party responsible for causing patient's injuries, health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity that is responsible for payment of the patient's hospital bill. I agree this assignment will allow the "Hospital" to pursue all legal and non-legal remedies against any such person and/or entity including the filing of a lawsuit as assignee of the patient. I agree that if it is necessary to retain legal counsel to enforce or utilize these assignment provisions, the "Hospital" is entitled to recover its attorney's fees and court cost as allowed by law. I understand that, subject to the terms of the applicable health plan(s), all persons signing this document may be financially responsible for charges not covered by this assignment of insurance benefits.

Release of Information for Insurance Billing Purposes

For the purpose of obtaining payment for services, I authorize the "Hospital" to disclose any and all medical billing records related to the patient's admission or outpatient visit, to a health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity responsible for payment of the patient's hospital bill. Medical Billing records may include, but are not limited, to records of toxicology screens, hepatitis test results, psychiatric or psychological treatment, alcohol abuse, drug abuse, blood alcohol levels, HIV testing results, AIDS treatment, other records relating to the patient's diagnosis and treatment, and other protected health information. I understand there is a potential for information disclosed related to this authorization to be subject to re-disclosure by the recipient and no longer be protected. This authorization is subject to revocation in writing at any time, except to the extent that the person or entity previously authorized to make the disclosure has already taken action. If not previously revoked, this authorization shall expire one year from the date it is signed by the patient.

Patient Identification

Assignment of Benefits and Financial Responsibility

Physicians Bill Separately

Some physicians are employees of the hospital and some are independent contractors, not agents or employees of the hospital. I understand that each professional group or individual practitioner who renders professional services to the patient, including, but not limited to the Radiologist, Pathologist, Emergency Physician, Anesthesiologist and Cardiologist, may bill and collect for his/her professional services separate from the hospital's billing and collections. I agree to pay for any physician services performed on the patient's behalf and billed to the patient unless the physician has entered into agreement with the patient's insurance company to accept payment in full or unless otherwise provided by law.This professional billing is subject to the authorizations granted by me in this consent agreement.

Financial Agreement:

I understand that all estimates of charges given to me represent the approximate cost and are not guaranteed. I have the right to request an itemized statement and an explanation of the billing. I understand that I, as the patient or appropriate guarantor, am obligated to pay the account of the hospital/provider/physician in accordance with the regular rates and terms of the "Hospital"/Provider/ Physician for the healthcare services the patient receives within 30 days of service, or if insured, within 30 days of either insurance benefits payment or denial. Should the account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the maximum legal rate. If payment is received from more than one source causing overpayment for this or any other period of hospitalization, I authorize application of the overpayment to any unpaid hospital bill for which the patient is legally responsible. I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release to the "Hospital" proof of my income. I understand that if any information I have given proves to be untrue, the "Hospital" will re-evaluate my financial status and take whatever action becomes appropriate and/or necessary.

Authorization for Receiving Messages and Automated Calls

I give the "Hospital" and its agents and/or other parties calling on behalf of the "Hospital" (including, but not limited to, debt collectors or others calling regarding your hospital visit, government or charity care programs) permission to contact me by telephone at the telephone number or numbers I provided during the registration process, or at any time in the future, including wireless telephone numbers or other numbers that may result in charges to me. The "Hospital" and its agents may leave messages for me at these numbers and may send text messages or email communications using the email address or addresses I provide. These voice messages and email and text communications may include information required by law (including debt collection laws) related to amounts I owe the "Hospital" as well as messages related to my continued care and treatment. I also understand that the "Hospital" and its agents or other parties calling on the "Hospital's" behalf may use pre-recorded/artificial voice messages and/or use an automatic dialing devise (an autodialer) to deliver messages related to my hospital visit, my account,whether I qualify for government programs, whether I qualify for charity care programs or amounts I may owe the "Hospital". I also authorize the "Hospital" and its agents to use the number or numbers provided for such pre-recorded or auto dial messages. If I want to limit these communications to a specific telephone number or numbers, I understand that I must request that only a designated number or numbers may be used for these purposes.

Medicare and Tricare Inpatients Only

I have received a copy of an IMPORTANT MESSAGE FROM MEDICARE (or TRICARE) regarding my rights as a Medicare or Tricare patient.

Patient Identification

Assignment of Benefits and Financial Responsibility

Medicare Certification, Authorization to Release Payment Information And Payment Request

I certify that the information given by me in applying for payment under title XVIII or XIX of the Social Security Act (Medicare) is correct. I authorize any holders of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on the patient's behalf.

When Written Authorization is Required for HMO/PPO Plans

I understand that if my health insurance carrier requires preauthorization, the "Hospital/Provider/ Physician cannot guarantee that the patient's visit will be covered without a written pre-authorization document from the insurance carrier. If the "Hospital/Provider/Physician cannot obtain authorization for the patient's visit, I will be responsible for the unpaid balance that will include any charges for this visit's services/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the "Hospital" accepts no liability for failure to meet my insurance carrier's pre-certification or post certification regulations that may be required of me. I agree to properly execute all pre-certification and post certification procedures.I understand that proper network/managed care indicators must be located either on my insurance card or the insurance company's explanation of benefits form to receive my managed care discount. I understand it is my responsibility to know if my managed care plan is affiliated with this "Hospital"/Provider(s) for services being provided to the patient.

Medicaid Managed Care Plans

I assign any and all insurance benefits payable to me to the "Hospital". I understand that I am responsible for payment for services rendered at the "Hospital" including excluded services from my insurance either because the plan deems such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or pre-existing conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney or collection expenses. I give permission to my insurance provider(s), including Medicare and Medicaid, to directly pay this Hospital for my care instead of paying me. I understand that I am responsible for any health insurance deductibles and co-insurance and non-covered services. I further assign my rights to this "Hospital", and hereby appoint this "Hospital" as my personal representative, to (i) submit claims for payment for services and treatment rendered to me to payors, including but not limited to Medicare and Medicaid, and further assign my rights to /for payment for services and treatment rendered to me, and (ii) appeal from any and all denials of coverage, without limitation, to the "Hospital".

Courtesy in Filing Insurance Claims

I understand that as a courtesy, the hospital will file insurance claims for hospital services. I waive any rights of action against the hospital and it's employees for omissions in submitting insurance claims. I understand that I remain liable to the hospital for charges for services and goods for which I am legally responsible.

Private Room: (If applicable)

I understand and agree that if I request and receive a private room, I am responsible for any additional charges associated with this request.

Assignment of Benefits and Financial Responsibility

Signatures - Please read before signing

This is to certify that I, the undersigned, being the patient, or another person legally authorized to act for the patient, have carefully read and fully understand this financial agreement and am duly authorized to execute the above and accept its terms.

The undersigned acknowledges having read and received copy of this document. A copy of this authorization shall be as valid as the original. The "Hospital's" provision of services to you is not contingent upon your signing this consent form.

Patient/Authorized Signature _____ Date/Time _____

Witness Signature _____ 2nd Witness Signature for Verbal Consent _____

Patient's Billing Address _____

_____

Centro de servicios de rehabilitación para pacientes ambulatorios de George Washington University (GWU)
2131 K St. NW | Suite 620 | Washington, DC 20037
Tel.: (202) 715-5655 | Fax: (202) 715-5664

Formulario de registro del paciente

Información del paciente				
Apellido	Nombre	Segundo nombre	Fecha / /	
Dirección de residencia				
Ciudad	Estado	Código postal	Teléfono principal	Teléfono alternativo
Sexo legal al momento del nacimiento M F	Fecha de nacimiento / /	Médico responsable de la derivación		
Información de contacto de emergencia				
Contacto de emergencia	Teléfono principal	Teléfono alternativo		
Relación con el paciente				

Información complementaria:

Idioma principal:

☐ Inglés ☐ Español ☐ Amárico ☐ Árabe ☐ Otro: _____

Centro de servicios de rehabilitación para pacientes ambulatorios de George Washington University (GWU) | Formulario de admisión para servicios de rehabilitación de salud del piso pélvico

2131 K St. NW | Suite 620 | Washington, DC 20037 | Tel.: (202) 715-5655 | Fax: (202) 715-5664

Nombre: _____ Fecha: ___ / ___ / ___ Médico responsable de la derivación: _____

Edad: _____ Pronombre preferido: _____

Percibo mi identidad de género como (marque su respuesta con un círculo): Mujer | Hombre | Intersexual | Mujer transgénero (transición de hombre a mujer) | Hombre transgénero (transición de mujer a hombre) | Sin género

Antecedentes actuales

Describa qué lo trae a fisioterapia hoy: _____

¿Cuánto tiempo hace que tiene estos síntomas? _____

¿Qué tipos de tratamientos recibió para mejorar sus síntomas (p. ej.: medicamentos, inyecciones, acupuntura, autoayuda)?

Me sentiría mejor si pudiera _____

Dolor: califique el grado de dolor que siente según una escala de 0 a 10 (0 = sin dolor; 10 = el dolor más intenso que pueda imaginar):
Durante un buen día: _____ Durante un mal día: _____

¿En qué parte del cuerpo siente dolor? _____

¿Qué hace que el dolor mejore? _____ ¿Qué hace que el dolor empeore? _____

Salud sexual	**Vejiga/intestinos**
¿Siente dolor durante las relaciones sexuales? ☐ Sí ☐ No Tipo de método anticonceptivo elegido (si corresponde) y cantidad de años que hace que lo usa: _____	¿Suele tener pérdidas involuntarias de orina? ☐ Sí ☐ No ¿Suele experimentar incontinencia fecal? ☐ Sí ☐ No Actividades que contribuyen a causar las pérdidas involuntarias de orina: _____ ¿Experimenta una sensación fuerte cuando tiene ganas de orinar? ☐ Sí ☐ No ¿Con qué frecuencia orina durante el día? (cada hora, cada dos horas, etc.) _____ ¿Cuántas veces se despierta a la noche para orinar? _____

Antecedentes médicos (marque con un círculo las opciones que correspondan)
Diabetes | Presión arterial alta | Migrañas | Cáncer | Enfermedad renal | Artritis | Osteoporosis | Accidente cerebrovascular | Fibromialgia | Problemas auditivos | Clostridium difficile | Estafilococo aéreo resistente a la meticilina (EARM) | Ninguno |
Otro: _____

Cirugías (marque con un círculo las opciones que correspondan)
Intestinal/rectal | Ginecológica | Parto por cesárea | De próstata | Abdominal | Otra (especifique) _____
Indique sus **antecedentes de embarazo/nacimiento:** (cantidad de partos por vía vaginal o por cesárea; incluya cualquier tipo de complicación que haya experimentado): _____

Medicamentos (todo lo que usted toma regularmente, incluidos los suplementos):

Alergias (alimentos, látex, medicamentos): _____

Antecedentes sociales

¿Cuál es su ocupación? _____
¿Trabaja en la actualidad? _____
Haga una lista de las actividades que realiza en su tiempo libre (incluya la actividad física y las aficiones): _____
¿Alguna vez fue víctima de abuso emocional, físico o sexual? ☐ Sí ☐ No
¿Es ansioso? ☐ Sí ☐ No ¿Se siente deprimido? ☐ Sí ☐ No ¿Tiene antecedentes de ansiedad o depression? ☐ Sí ☐ No
¿Cuáles son los principales factores de estrés en su vida (si hay alguno)?
¿Hay algo que quisiera decirnos y que no le hemos preguntado? _____

¡Gracias por ayudarnos a ayudarle!

Firma del paciente: _____ Firma del terapeuta: _____

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

Formulario de admisión para servicios de rehabilitación de salud del piso pélvico

Etiqueta del paciente

HP4016

76-254 (5/18)

DOB: SX:
MRN:

INFORMED CONSENT FOR PELVIC FLOOR EVALUATION
GWU HOSPITAL

I understand and acknowledge that I have been referred to, and/or self elected to see a pelvic floor trained physical therapist for the treatment of my pelvic floor dysfunction. Pelvic floor dysfunctions include but are not limited to urinary or fecal incontinence, urgency or pain conditions, pain or discomfort with sexual function, pelvic girdle pain (including low back, sacroiliac, and hip pain), pregnancy related pelvic girdle pain, postpartum pain, testicular/penile pain, and endometriosis.

In addition to an orthopedic lumbopelvic assessment, it is often necessary to complete an assessment of the pelvic floor musculature and function. This MAY involve an internal assessment of the pelvic floor muscles which could be completed either vaginally or rectally. This examination will assess skin condition, reflexes, muscle tone and function. Based on our findings, sessions might include continued internal treatments to address muscle spasm and pain, and training for optimal strength and relaxation of your pelvic floor muscles.

Your Physical Therapist will discuss examination and treatment options BEFORE initiating the exam, and at any time during your session you can say NO for *any* reason. We realize that many patients are often apprehensive due to the private nature of this examination and we ENCOURAGE you to ask as many questions as possible to help increase your comfort.

Consent:

I have read and understand the Informed Consent for Pelvic Floor muscle evaluation and I consent to the evaluation and treatment, unless otherwise noted below.

Patient _____ Date _____

Therapist _____ Date _____

You have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment. This can be a family member, friend, or if requested, a GW outpatient clinical staff member. This is your RIGHT to request or decline.

___ YES I want a second person in the room for the pelvic floor evaluation and treatment

___ NO I decline a second person in the room for the pelvic floor evaluation and treatment

Patient _____ Date _____

Name of Chaperone _____ Date _____

Therapist _____ Date _____

Recibo de aviso de prácticas de privacidad

Acepto haber recibido el Aviso de prácticas de privacidad del hospital.

(Firma del paciente)	(Fecha)

(Representante autorizado del paciente)	(Relación con el paciente)	(Fecha)

(Firma del testigo)	(Puesto laboral del testigo)	(Fecha)

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

Recibo de aviso de prácticas de privacidad

Receipt of Notice of Privacy Practices

CL0040

40-100SPN (11/15)

Patient Label

DOB:

MRN:

SX:

Aviso de participación de GWUH en el CRISP

El CRISP, Chesapeake Regional Information System for our Patients, Inc., es un sistema de intercambio de información de salud (Health Information Exchange, HIE) que originariamente comenzó en el estado de Maryland y que recientemente se amplió para incluir al Distrito de Columbia.

El CRISP se toma la privacidad del paciente muy seriamente y reconoce que el HIE no puede tener éxito si los pacientes no confían en que su información es segura. Proteger la información del paciente en el HIE del CRISP es una prioridad. El CRISP cumple todas las leyes estatales, del distrito y federales (por ejemplo la Ley de Portabilidad y Responsabilidad del Seguro Médico (HIPPA)) para proteger la información del paciente.

The George Washington University Hospital ha elegido participar en el CRISP. Según lo permite la ley, su información de salud se compartirá con este sistema de intercambio para proporcionar un acceso más rápido, una mejor coordinación de la atención y para asistir a los proveedores y a los funcionarios de salud pública para tomar decisiones más informadas.

Su firma indica que a usted se le notificó acerca de la participación de GWUH en el intercambio de información de salud del CRISP.

Firma del paciente o del representante autorizado _____ Fecha _____

Representante del Hospital _____ Fecha _____

- **Usted puede "excluirse" y deshabilitar todo acceso a su información de salud que se encuentre disponible a través del CRISP, llamando al 1-877-952-7477, o al completar y enviar un formulario de exclusión a CRISP por correo electrónico, fax o mediante el sitio web, ingresando a: www.crisphealth.org**