Welcome to the George Washington University Hospital Outpatient Rehabilitation Center. We welcome the opportunity to work with you and help you resume your normal activities. Based on the evaluation performed at your first session, an individual treatment plan will be developed to meet the goals established by you and your therapist.

A Physician's prescription or referral is required in order for you to be seen by a therapist. It needs to be dated within 30 days of the evaluation date.

To Schedule an Appointment:
- Call (202) 715-5655, Monday through Friday, between 8:00am-4:30pm.
- The initial evaluation appointment is scheduled for 45 minutes for Physical Therapy and an hour for Speech and Occupational Therapy.
- Follow-up appointments are scheduled for 30 minutes, unless specified by your therapist (Speech Pathology is a 60 minute treatment session).
- Generally, follow-up appointments can be scheduled 2-3 weeks in advance (this can be done after the evaluation has been completed).
- If you have not been seen in the last 30 days, you would be discharged from therapy and you will need a new prescription or referral from your physician and be scheduled for another initial evaluation, if you wish to restart therapy.

To Cancel an Appointment:
- Please call (202) 715-5655 at least 24 hours in advance. If a 24-hour notice is not provided, a late fee may be incurred.

Attire:
- Please wear suitable clothing to allow for exposure of the area to be treated. Arrive early to ensure adequate time to change your clothes if necessary.

Other:
- It is your responsibility to check your insurance to verify coverage for outpatient therapy.
- Your appointment time is not guaranteed if you are 10-15 minutes late; you may have to reschedule.
- If (2) two appointments in a row or (3) three appointments within a 30-day time frame is missed or canceled you would be discharged from therapy.
- For any billing questions, please call (202) 715-4905.

I have read and understood the above information.

Signature: ___________________________ Date: _____________________

Let us know how we can serve you better. You comments and suggestions are appreciated.
No Show/Cancellation Policy

- It is the client’s responsibility to notify the clinic at least 24 hours in advance in order to cancel or reschedule an appointment without penalty.
  
  *Please call no later than 4:00pm on the day before your scheduled appointment.*

- Clients who fail to give 24-hour notice will be documented as a “no-show” in their file.

- Any client who cancels/no-shows for 2 appointments in a row or cancels/no-shows for 3 appointments within a 30-day time frame will be discharged from therapy.

- Discharged clients are required to get a new prescription from their referring physician and schedule an initial evaluation to return to therapy.

- Clients who arrive more than 15 minutes past their appointment time will not be seen.

*The 30-day time frame will begin on the date of your initial evaluation and end 30 days thereafter.

*While we empathize with each individual’s situation, please understand our need to standardize our policies. Therefore, ALL patients who accumulate 3 no-shows within a 30-day time frame or cancel or no-show for 2 appointments in a row will be discharged, regardless of personal situation.

Thank you for your co-operation in this matter.

Strategies to reduce your No shows/Cancellations

- Keep your appointment schedule up to date. The earlier you schedule your follow-up appointments, the more likely you are to get the appointment times that work best for you.

- Be flexible. If you find that you are unable to attend your appointment for a specific time and day, call our front desk to see if there are other openings during the same day.

- If you are uncertain as to whether or not you have an appointment, or are uncertain as to the time of your appointment, call us! We’ll be glad to confirm!

- Keep our business card in your wallet so that you have our contact information.

- Leave messages! Our front desk can be very busy during certain times, but will receive your message. A voice mail left by 4:00 pm on the day prior to your appointment will be accepted as advance notice.

- Those who require transportation services should ask for an earlier pick-up time, therefore you’ll be on time for your appointment. Be certain to make transportation arrangements well in advance of your therapy appointments.

*Please bring your appointment slip when you come for your therapy appointment.

*To ensure that you are seen at your appointment time, please sign in at the front desk when you arrive for your appointment.*
Respecting
Your Privacy

This Notice describes how dental information about you may be used and disclosed and how you can get access to this information and review it carefully.

PROTECTED HEALTH INFORMATION
Information about your health is private. It should remain private. That is why this healthcare organization is required by federal and state law to protect the privacy of your health information. We are "covered entities" under federal health insurance laws.

WHO WILL FOLLOW THIS NOTICE
This Notice describes the privacy practices followed by the hospital employees, volunteers, and related personnel.

The procedures described in this Notice may be followed by health care providers, who are members of our staff, if they have been asked to abide by its contents. Many of our doctors follow the practices contained within this Notice. Other physicians have created their own Notice. Those members of the Medical Staff who do not wish to abide by this Notice are required to give you a separate Notice that will explain their privacy practices.

Each participant who joins this joint Notice of Privacy Practices agrees to follow the joint Notice for all aspects of HIPAA Compliance. Other than the tracing of this joint Notice, for physicians' specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted out of the Notice, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Practices
- HealthCare: A Guide to Understanding Your Rights

Your personal doctor may have different policies regarding the use and disclosure of PHI created in their office.

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT
During the course of your treatment, we are free to use and disclose your PHI. For example, if you asked for an appointment, we will make the staff aware of your request. We will use your PHI to follow the doctor's orders for an in-hospital procedure or other types of treatment-related procedures.

For services, we may disclose PHI for the purposes of treatment and due care.

FOR PAYMENT
If you ask for a change in your health information, we may disclose this information to other persons involved in your care. For example, when you ask for a copy of your record, we will give you the information needed to sustain your health or to provide safe and effective treatment.

FOR HEALTHCARE OPERATIONS
Your medical record and PHI could be used in periodic assessments by physicians about the hospital's overall quality. Or we might use the PHI from real patients in education settings with medical students working in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a compliant.

SPECIAL USES
Your relationship to us as a patient might require using or disclosing your PHI in order to:

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about your health benefits and services
- Ask you to evaluate our charitable services without telling you to not ask.

Your Authorization May Be Required
In many cases, we may use or disclose your PHI, as permitted above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, you must give us your written authorization before we disclose specific categories of PHI. In such a case, we will keep your authorization under specific categories of PHI and will keep a list of your PHI that we use or disclose.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW
As a hospital, we must abide by many state and regulations that either require us to permit or restrict the use or disclosure of your PHI.

REQUIRING OR PERMITTED USES AND DISCLOSURES
If you do not wish to be identified by object, we may include information identifying you in a 'window' directory of patients which are on inpatient care. This information may include your name, general condition and religious affiliation of your care.

If you do not wish to be identified by your PHI, we may collect some of your PHI with a written or oral agreement made in your case.

We may use your PHI in an emergency when you are not able to give consent.

We may use and disclose your PHI for research if we believe certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI
When required by law, for example when ordered by a court.

For public health activities including reporting a communicable disease or other risk to the food and Drug Administration.

To report neglect, abuse or domestic violence.

To government regulators or agents to determine compliance with applicable rules and regulations.

As required by administrative procedures to respond to a valid subpoena.

To a person for purposes of identifying a deceased person or determining cause of death, or to a funeral director for releasing burial arrangements.

For purposes of research, when a research oversight committee, established an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.

For creating statistical types of health information that eliminate all legally protected identifying information that could directly identify the subject of the information.

In accordance with the legal requirements of a written comprehensive data use and disclosure policy.

When you request, by law enforcement officials, for the sole purpose of reporting serious crimes, reporting a suspicious death or the death of any legal requirements.

When we reasonably believe that the receipt or disclosure will warrant a health alert or to respond to a threat to public safety including an investigation and alerted personal physician.

In connection with certain types of health care programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM
Under the federal regulations, you have specific rights. However, we will not refuse to disclose your PHI that you request. If we do agree to your request, we will abide by the agreement.

YOUR RIGHT TO CONSENT AND DISCLOSURE
You have the right to consent to and receive a copy of your PHI. For example, if you have been a patient at our hospital, you may request a copy of your record at any time. However, you cannot refuse to receive a copy of your record. If we do agree to your request, we will abide by the agreement.

YOUR RIGHT TO AMEND YOUR PHI
If you disagree with your PHI within our records, you have the right to amend, or correct, any PHI that you believe is incorrect or incomplete. For example, if we have transcribed your PHI incorrectly, you may request that we correct it. If we disagree with your request, we will inform you of our decision and allow you the opportunity to have your request placed in your PHI.

YOUR RIGHT TO HARMONY
If you disagree with your PHI within our records, you have the right to object to the use or disclosure of your PHI. For example, if we are conducting a research study, you may request that we discontinue your PHI. However, if we have already disclosed your PHI to a third party, we may be required to disclose your PHI to that third party.

YOUR RIGHT TO LIMIT DISCLOSURE
If you have the right to limit the use or disclosure of your PHI. For example, if we are conducting a research study, you may request that we limit the use or disclosure of your PHI. However, if we have already disclosed your PHI to a third party, we may be required to limit the use or disclosure of your PHI.

YOUR RIGHT TO ACCESS YOUR PHI
You have the right to access your PHI. For example, if we are conducting a research study, you may request that we provide you with a copy of your PHI. However, if we have already disclosed your PHI to a third party, we may be required to provide you with a copy of your PHI.

YOUR RIGHT TO INSPECTION AND COPY
You have the right to inspect your PHI. For example, if we are conducting a research study, you may request that we provide you with a copy of your PHI. However, if we have already disclosed your PHI to a third party, we may be required to provide you with a copy of your PHI.

YOUR RIGHT TO AMEND YOUR PHI
If you have the right to request that we amend your PHI. For example, if we are conducting a research study, you may request that we amend your PHI. However, if we have already disclosed your PHI to a third party, we may be required to amend your PHI.

WHAT IF I HAVE A COMPLAINT?
If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or discriminate against you for filing a complaint.

Some of our privacy obligations and how we fulfill them:

Federal health information privacy policies require us to give you notice of our policies. This document is our notice. We will abide by the privacy policies that are in effect. However, we reserve the right to change this notice and our privacy practices when permitted or required by law.

If we change our notice of privacy practices, we will provide you with written notice of your rights to amend or to limit the use or disclosure of your PHI.

Compliance with certain state laws:

When we are conducting a research study, we will provide you with a copy of your PHI. However, we reserve the right to change this notice and our privacy practices when permitted or required by law.

By law, we must protect your privacy when conducting research. However, we reserve the right to change this notice and our privacy practices when permitted or required by law.

Some of our privacy obligations:

To comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to provide you with this Notice of Privacy Practices. This Notice describes how your PHI may be used and disclosed and how you can get access to this information and review it carefully.

We are required to follow the terms of this Notice while it is in effect. We will not change the terms of this Notice without giving you notice of the change. If you have any questions about this Notice, please contact our Privacy Officer at the phone number listed on the back of this Notice.
Respetando tu Privacidad

INFORMACIÓN DE SALUD PROTEGIDA
La información que solicitas puede ser considerada confidencial y, por lo tanto, que permitas su acceso, podrá ser utilizada de diferentes maneras, incluyendo para fines de investigación, supervisión, y análisis de calidad del Hospital. Por favor, revisa las políticas y procedimientos del Hospital antes de realizar el uso.

USOS ESPECIALES
Si deseas recibir información sobre el uso de la información de salud, puedes hacerlo a través de nuestro sitio web o poniéndote en contacto con nuestro Departamento de Protección de Datos personales.

SE LE PEDIRÁ QUE AUTORIZEN LA UTILIZACIÓN De esta información para fines de investigación, supervisión, y análisis de calidad del Hospital. Por favor, revisa las políticas y procedimientos del Hospital antes de realizar el uso.

ALGUNOS USOS Y DIVULGACIONES DE SU ISP REQUIEREN O PERMITEN POR LEY
Para obtener el permiso para el uso de la información de salud, generalmente se requiere el consentimiento del individuo.

SU DERECHO A COMUNICACIÓN CONFIDENTIAL
El uso de la información de salud, incluyendo la confidencialidad del tratamiento, puede ser utilizado en diferentes situaciones, incluyendo para fines de investigación, supervisión, y análisis de calidad del Hospital. Por favor, revisa las políticas y procedimientos del Hospital antes de realizar el uso.

SU DERECHO A REVISAR SU AUTORIZACIÓN
El uso de la información de salud puede ser utilizado para fines de investigación, supervisión, y análisis de calidad del Hospital. Por favor, revisa las políticas y procedimientos del Hospital antes de realizar el uso.

SU DERECHO A INFORMAR Y OBTENER COPIA
El uso de la información de salud puede ser utilizado para fines de investigación, supervisión, y análisis de calidad del Hospital. Por favor, revisa las políticas y procedimientos del Hospital antes de realizar el uso.

SU DERECHO A ENMendar SU ISP
El uso de la información de salud puede ser utilizado para fines de investigación, supervisión, y análisis de calidad del Hospital. Por favor, revisa las políticas y procedimientos del Hospital antes de realizar el uso.

SU DERECHO A SABER QUIÉNES Tienen ACCESO A SU ISP
El uso de la información de salud puede ser utilizado para fines de investigación, supervisión, y análisis de calidad del Hospital. Por favor, revisa las políticas y procedimientos del Hospital antes de realizar el uso.

ALGUNAS DE NUESTRAS OBLIGACIONES Y COMO LAS CUMPLIMOS
La seguridad de la información de salud es esencial para garantizar su confidencialidad y protección.

PARTICIPACIÓN CON CIERTAS LEYES ESTATALES
Cuando sean aplicables a su ISP, el Hospital llevará a cabo la protección de su información personal.

PLÁTICA DE PRIVACIDAD Y CONOCE SU DERECHO
Para obtener más información sobre cómo proteger su información personal, puede ser necesario consultar con nuestro Departamento de Protección de Datos personales.

FUEGO DE ELECCIÓN
Esta sección se actualizó el 1 de julio de 2023. Versión 4 (07/01/2023)
Receipt of Notice of Privacy Practices

I acknowledge that I have received the hospital’s Notice of Privacy Practices.

_________________________________________     ________________
(Patient's Signature)                                                      (Date)

_________________________________________     ___________________________        _________________
(Patient's Authorized Representative)                            (Relationship to Patient)                       (Date)

_________________________________________     ___________________________        _________________
(Witness Signature)                                                        (Witness Job Title)                                (Date)
GENERAL POLICY: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, sexual orientation, age or handicapping condition.

CONSENT TO TREATMENT: I have come to The George Washington University Hospital for medical treatment. I ask the health care professionals at the Hospital to provide care and treatment for me that they feel is necessary. The undersigned consents to the procedures, which may be performed during this hospitalization, or on an outpatient basis including emergency treatment or services. I consent to undergo routine tests and treatment as part of this care. These may include but are not limited to laboratory, radiology, medical or surgical tests, treatments, anesthesia or procedures as directed under the general and special instruction of the physician or surgeon. I understand that I am free to ask a member of my health care team questions about any care, treatment or medicine I am to receive. Because The George Washington University Hospital is a teaching hospital, I understand that my health care team will be made up of hospital personnel (to include nurses, technicians, and ancillary staff) under the direction of my attending physician and his/her assistants and designees (to include interns, residents, fellows and medical students). I am aware that the practice of medicine is not an exact science and admit that no one has given me any promises or guarantees about the result of any care or treatment I am to receive or examinations I am to undergo.

PHYSICIANS NOT AS EMPLOYEES: I understand that each physician is an independent contractor who is self employed and is not the agent, servant or employee of the hospital. I understand that I may receive separate billing from each of these providers for services rendered.

RELEASE OF INFORMATION: The George Washington University Hospital is authorized to release any information necessary, including copies of my hospital and medical records, to process payment claims for health care services which have been provided, and to duly authorized local and federal regulatory agencies and accrediting bodies as required or permitted by law. George Washington University Hospital is further authorized to release demographic information to organizations performing patient satisfaction surveys. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide The George Washington University Hospital information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by myself. I release and forever discharge The George Washington University Hospital, its employees and agents, and my attending physician from any liability resulting from the release of my medical records or information from them for payment purposes. I understand that my name will be displayed in the signage system outside my hospital room.

PERSONAL VALUABLES: THE GEORGE WASHINGTON UNIVERSITY HOSPITAL WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CLOTHES, PERSONAL PROPERTY OR VALUABLES.

NON-SMOKING POLICY: In accordance with regulatory agency standards, the Hospital is a non-smoking facility.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS: I assign any and all insurance benefits payable to me to The George Washington University Hospital. I understand that I am responsible for payment for services rendered at the Hospital including services excluded by my insurance and services not medically necessary. I understand that any insurance benefits are the property of the Hospital. The Hospital is further authorized to assign any and all insurance benefits payable to me to The George Washington University Hospital under the regulations of any and all federal regulatory agencies and accrediting bodies as required or permitted by law. George Washington University Hospital is further authorized to release demographic information to organizations performing patient satisfaction surveys. Such records may include information of a psychological or psychiatric nature, relating to my mental condition or treatment for conditions relating to the use of alcohol or drugs. I understand that I am responsible for attorney or collection expenses. I give permission to my insurance provider(s), including Medicare and Medicaid, to directly pay The George Washington University Hospital for my care instead of paying me. I understand that I am responsible for any health insurance deductibles or co-insurance and non-covered services.

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 other as required, I authorize my employer to release to The George Washington University Hospital proof of my income. I understand that if any information I have given proves to be untrue, The George Washington University Hospital will re-evaluate my financial status and take whatever action becomes appropriate. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by signing it, I am agreeing to it.

X _________________________ Signature of patient or responsible party

Date ________________ Witness ________________________

Hospital Representative ________________ Date ______________

Section 1:
Did you bring an Advance Directive (Living Will/Health Care Power of Attorney) form with you?  

☐ Yes  ☐ No

(If YES, place a copy in the front of the patient's chart / If NO, go to Section 2)

Section 2:
1. I was given information on formulating an Advance Directive (including how to obtain assistance with completing the Advance Directive form). _______ initials OR

2. I do not have an Advance Directive and do not wish to formulate one. _______ initials

By my signature below, I consent to laboratory studies (HIV, HBV, HCV) in the event a health care worker is exposed to my blood or body fluids. I consent to the appropriate disposal of any tissue or part removed from my body and to the taking of photographs during the procedure/operation/treatment for research, teaching, or scientific purposes as long as my identity is not disclosed.

Signature ________________________ Date ______________

By my signature below, I consent to laboratory studies (HIV, HBV, HCV) in the event a health care worker is exposed to my blood or body fluids. I consent to the appropriate disposal of any tissue or part removed from my body and to the taking of photographs during the procedure/operation/treatment for research, teaching, or scientific purposes as long as my identity is not disclosed.

Signature ________________________ Date ______________

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

PATIENT AUTHORIZATION FORM

80-010 (07/15)
**Patient Registration Form**

**Part 1 - Patient's Information**

<table>
<thead>
<tr>
<th>Patient's Last Name</th>
<th>First</th>
<th>Middle</th>
<th>Date of Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Apt. Number/P.O. Box</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Home Telephone</th>
<th>Work Telephone</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient's Occupation</th>
<th>Employer</th>
<th>Work Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient's Sex</th>
<th>Birth Date (Mo./Day/Year)</th>
<th>Patient's Social Security Number</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>/ /</td>
<td></td>
<td>S</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td>M</td>
</tr>
</tbody>
</table>

**Part 2 - Emergency Contact Information**

<table>
<thead>
<tr>
<th>Next of Kin or Emergency Contact</th>
<th>Home Telephone</th>
<th>Work Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address (Street, City, State)</th>
<th>Zip Code</th>
<th>Relationship to Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Referring Physician (If Applicable)</th>
<th>Physician's Address (Street, City, State, Zip Code)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Dr.</th>
<th>Dx.</th>
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</tbody>
</table>

**Date Sent to Admitting Office:**

**Please Complete:** (Circle and/or Indicate)

- **Country of Birth:** U.S.A. Others (Please Specify): __________
- **Primary Language:** English Others (Please Specify): __________
- **Religion:** __________

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**The George Washington University Hospital**

Outpatient Rehab
Patient Registration

80-647 (05/15)
Date:__/__/__  Height: __________  Weight: ________  Referring Physician: __________

Why were you referred for therapy?

*REQUIRED: Medical History: (Please check all that apply)

- Heart Disease
- Diabetes
- High Blood Pressure
- Pacemaker
- Osteoporosis
- Cancer
- Tuberculosis
- Visual Impaired
- Epilepsy
- Hepatitis
- HIV/AIDS
- Arthritis
- Hearing Impaired
- Fibromyalgia
- Pregnant
- Stroke
- Asthma
- Latex Allergy
- Scoliosis

*REQUIRED: Medications: Please list all current medications including dosage and supplements:

*REQUIRED: Allergies (drug, food, latex): NO:____  If YES, list all allergies:

Have you had any type of therapy for this condition in the past?  Y  N  Was it effective?  Y  N

Are you currently receiving other treatments for this condition (eg. Chiropractor, Acupuncture)?  Y  N

Have you had surgery for your condition?  Y  N  If yes, please give approximate date:

Have you had any injections for your condition?  Y  N  If yes, please give approximate date:

Please list any diagnostic tests you have had for this condition:

Have you fallen in the past 3 months?

What is your current problem?

When did the problem first occur?

How did the problem occur?

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)

   Worst pain since onset:__________  Best pain since onset:__________  Today's pain:__________

What makes your pain / problem better?__________  Worse?__________

Would you like to speak to someone regarding abuse or neglect that you have recently experienced?  Y  N

Employment History:

Are you currently working?  Y  N  If no, how many total days of work have you missed?__________

Are your work duties?  □ Full  □ Restricted  How many hours per week do you work?__________

Who is your employer?

What type of work do you do?

What type of non-work activities are you involved in?

Do you have any transportation concerns?  Y  N

What do you hope to accomplish with therapy?

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at George Washington University Hospital Outpatient Rehabilitation Center.

Patient Signature:________________________  Therapist Signature:________________________