THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

OUTPATIENT REHABILITATION CENTER

2131 K STREET NW, SUITE 620
WASHINGTON, DC 20037
OFFICE #: 202-715-5655 FAX #: 202-715-5664

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.

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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 MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect the privacy of your health information. We call it "Protected Health Information" (PHI).

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted 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 opt not to abide by this Notice are required to give you a separate Notice that will explain their privacy practices.

Each participant who joins in this Joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician 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 to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

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

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

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 our other health benefits and services
- Ask you to contribute to our charitable activities unless you tell us not to ask.

Your Authorization May Be Required

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRE OR PERMITTED USES AND DISCLOSURES

- If you do not verbally object, we may include information identifying you in a visitors' directory of patients while you are an inpatient in our hospital. This information may include your name, general condition and religious affiliation, if any.
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive 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 adverse drug reaction 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.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an Institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communication from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

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 penalize you for filing a complaint with the facility or the Secretary.

- To file a complaint with us, please contact the hospital's Risk Management Department or call the UHS Compliance Hotline at 1-800-852-3449. Your complaint should provide specific details to help us in investigating a potential problem.

- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C.20201 or call 1-877-696-6775.

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

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

If we change our notice of privacy practices, we will provide our revised notice to you when you next seek treatment from us.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

EFFECTIVE DATE: This notice takes effect on July 14, 2003. Version #10803EJ

Respetando Su Privacidad

ESTA NOTIFICACION DESCRIBE COMO PUEDE USARSE O DIVULGARSE SU INFORMACION MEDICA Y COMO USTED PUEDE TENER ACCESO A ELLA. POR FAVOR LEALA CUIDADOSAMENTE

INFORMACION DE SALUD PROTEGIDA

La información acerca de su salud es privada y tiene que permanecer privada. Es por ello que las leyes estatales y federales requieren que esta Institución de salud proteja la privacidad de la información de salud del paciente, la cual llamamos "Información de Salud Protegida" (ISP.)

QUIEN SEGUIRA ESTA NOTIFICACION

Esta notificación describe las prácticas de privacidad de información seguidas por nuestros empleados del hospital, voluntarios, y personal afiliado.

Las prácticas descritas en esta notificación también pueden ser seguidas por otros proveedores de servicios de salud, que son miembros de nuestra facultad médica, si han optado atenerse a su contenido. Muchos de nuestros doctores se acatan a las prácticas contenidas en esta notificación. Los miembros de nuestra facultad médica que optan por nó atenerse a esta notificación tienen la obligación de entregarle una notificación por separado que explica sus prácticas de privacidad.

Cada participante que se une a esta Notificación Conjunta de Prácticas de Privacidad, actua como su propio agente en todos los aspectos de conformidad con HIPAA, con excepción de la entrega de esta Notificación Conjunta. Para preguntas referentes a un médico en particular, por favor comuníquese directamente con ese doctor.

Empleados del Hospital, voluntarios y otro personal relacionado, incluyendo aquellos miembros del personal medico que han optado cumplir con este contenido, deben seguir este Aviso con respecto a:

- Uso de Información de Salud Protegida
- Divulgación de Información de Salud Protegida a otros
- Derechos de Privacidad del Paciente
- Nuestras obligaciones sobre Privacidad
- Contactos con el Hospital para más información, o si es necesario, formular una reclamación.

Es possible que su médico personal tenga políticas diferentes referente al uso y divulgación del ISP creada en sus oficinas.

USO O DIVULGACION DE SU INFORMACION DE SALUD PROTEGIDA

PARA TRATAMIENTO

Durante el curso de su tratamiento, el Hospital usa y divulga su ISP. Por ejemplo, si se hace un estudio de sangre en nuestro laboratorio, el técnico compartirá a los resultados con su médico. El Hospital también podría utilizar su ISP para el seguimiento del tratamiento ordenado por su médico para rayos x, procedimientos quirúrgicos u otros tipos de procedimientos relacionados.

PARA PAGO

Una vez recibido su tratamiento, el Hospital solcita el cobro a su plan médico. Alguna información del paciente podría entrarse en nuestras computadoras para facturar a su aseguradora. Podría incluir una descripción de su problema de salud, el tratamiento ofrecido, y el número de membresía en el plan de salud de su patrono. Un representante de su aseguradora también podría revisar su expediente médico para determinar si el servicio ofrecido era necesario. También podríamos divulgar ISP para reclamo de pagos no efectuados.

PARA EL FUNCIONAMIENTO DE LAS OPERACIONES INSTITUCIONALES

Su expediente médico e ISP podría ser utilizado para la evaluación de procesos de calidad del Hospital. Además, podríamos usar la información protegida de pacientes en procesos educativos con estudiantes del campo de la salud entrenándose en nuestro Hospital. Otros posibles usos incluirían la planificación de los servicios del Hospital o en la resolución de reclamaciones.

USOS ESPECIALES

Su relación con nosotros como paciente podría requerir el uso o divulgación de ISP para:

- Recordatorio de citas para tratamientos médicos
- Informarle sobre alternativas y opciones de tratamiento
- Informarle acerca de otros beneficios y servicios
- Solicitarle contribución en actividades caritativas, a menos que usted nos indique lo contrario.

SE LE PODRIA SOLICITAR SU AUTORIZACION

En muchos casos podemos usar o divulgar su ISP, según explicado anteriormente, para tratamiento, cobro, operaciones de salud, o según requerido o permitido por ley. En otros casos, necesitamos solicitarle autorización por escrito con instrucciones específicas y limitaciones sobre nuestro uso y divulgación de su ISP. Usted podría revocar su autorización si así lo desea.

ALGUNOS USOS Y DIVULGACIÓN DE SU ISP REQUERIDA O PERMITIDA POR LEY

Como institución hospitalaria, debemos cumplir con muchas leyes y regulaciones que nos requieren o permiten el uso o divulgación de su ISP.

USOS Y DIVULGACIONES REQUERIDAS O PERMITIDAS

- Si usted no objeta verbalmente, podríamos incluir durante su estadía en nuestro Hospital, información para los visitantes que lo identifica a usted en el directorio de pacientes. Esta información podría incluir su nombre, condición general, así como su religión, de usted practicar alguna.
- Si usted no objeta verbalmente, podríamos compartir alguna información protegida con algún miembro de su familia o amigo envuelto en su cuidado.
- Podríamos utilizar información protegida en caso de emergencia, mientras usted no esté capacitado para expresarse por usted mismo.
- Podríamos utilizar información protegida para investigaciones científicas siempre que hayan salvaguardas para proteger su privacidad.

OTROS USOS O DIVULGACION DE INFORMACION PROTEGIDA

- Cuando sea requerido por ley, por ejemplo, si un Tribunal lo ordena.
- En actividades de salud pública, lo que incluye reportar enfermedades transmisibles, o reportar reacciones adversas a medicamentos a la Administración de Drogas y Alimentos (FDA, por sus siglas en Inglés).
- Para reportar negligencia, abuso o violencia doméstica.
- A agentes o reguladores gubernamentales para determinar el cumplimiento con las reglas y regulaciones aplicables.
- En procedimientos judiciales o administrativos conforme un subpoena válido.
- A un médico forense para identificar a una persona fallecida o determinar la causa de la muerte, o a un director de funeraria para los arreglos funerarios.
- Para propósitos de investigación científica cuando el comité de revisión de investigaciones, llamada Junta de Revisión Institucional (I.R.B. por sus siglas en Inglés), determine que existe un riesgo mínimo a la privacidad de su ISP.
- Para crear tipos especiales de información de salud donde por ley se eliminan datos que le identifican o información que identifique directamente al sujeto de la misma.
- Conforme requisitos legales del programa del Fondo del Seguro del Estado.
- Cuando oficiales de ley lo soliciten debidamente, como por ejemplo, para reportes de heridas de balas, reporte de muerte sospechosa, u otros requisitos legales.
- Si entendemos razonablemente que el uso o divulgación de información protegida evitaría un peligro a la salud o para actuar en caso de una amenaza a la seguridad pública, incluyendo un crimen inminente contra otra persona.
- Para propósitos de seguridad nacional incluyendo al Servicio Secreto o si usted pertenece a las Fuerzas Armadas y se considera necesario por las autoridades militares competentes.
- Con relación a ciertos programas de donación de órganos.

SUS DERECHOS DE PRIVACIDAD Y COMO EJERCERLOS

Bajo el programa de privacidad requerido por las leyes federales los pacientes tienen derechos definidos.

SU DERECHO A SOLICITAR USO O DIVULGACION LIMITADA

Usted tiene el derecho de solicitar que nosotros no usemos o divulguemos su ISP en ciertas maneras. Sin embargo, no estamos obligados a acatar su solicitud. Si aceptamos su solicitud, debemos acatarnos a ese acuerdo.

SU DERECHO A COMUNICACION CONFIDENCIAL

Usted tiene derecho de recibir del Hospital comunicación confidencial en un lugar que usted especifique. Su solicitud tiene que ser por escrito, informando la otra dirección y explicando si esta solicitud podría interferir con el método de pago.

SU DERECHO A REVOCAR SU AUTORIZACION

Usted puede revocar por escrito la autorización que nos otorgó para el uso y divulgación de ISP. Sin embargo, si hemos actuado basándonos en su consentimiento o autorización, podremos utilizar o divulgar su ISP hasta el momento en que sea revocado.

SU DERECHO A INSPECCIONAR Y OBTENER COPIA

Usted tiene el derecho de inspeccionar y obtener copia de su ISP. Nosotros tenemos el derecho de negarle acceso a su ISP si entendemos que ésta pudiera causarle daño, pero tendríamos que explicarle la razón y proveerle una persona de contacto para la revisión de nuestra denegación.

SU DERECHO A ENMENDAR SU ISP

Si no está de acuerdo con el ISP en nuestros registros, usted tiene el derecho de solicitar por escrito que enmendemos su ISP si dicha información fue creada por nosotros o se mantiene para nosotros. Podríamos negarnos a enmendar y usted tiene el derecho de indicar su desacuerdo por escrito. Su declaración y nuestra contradeclaración tienen que formar parte de nuestros registros sobre usted.

SU DERECHO A SABER QUIENES TIENEN ACCESO A SU ISP

Usted tiene el derecho a solcitar un registro de ciertas divulgaciones de su ISP de los 6 años anteriores, realizadas apartir del 14 de abril del 2003. No estamos obligados a informarle todas las divulgaciones, tales como las hechas a usted, autorizadas por usted, u otras referentes a su tratamiento, pagos y operations hospitalarias, según lo descrito arriba. No habrá cargo para un registro anual, pero podrían haber cargos para registros adicionales. Le informaremos si hay un cargo, y usted tendrá el derecho de retirar su solicitud o efectuar el pago para proceder.

QUE HAGO SI TENGO UNA RECLAMACION?

Si usted entiende que su privacidad ha sido violada, puede radicar una reclamación con nosotros o con el Secretario de Salud y Servicios Humanos en Washington, D.C. No habrá represalia o penalización hacia usted por haber sometido una reclamación, ya sea con nosotros o con el Secretario.

Para radicar una reclamación con nosotros, por favor comuníquese con nuestro Departamento de Manejo de Riesgos, o comuníquese con el UHS Compliance Hotline al 1-800-852-3449. Su reclamo debe detallar información específica para ayudarnos a investigar un problema potencial.

Para llenar una reclamación con el Secretario de Salud y Servicios Humanos, puede escribir a: 200 Independence Ave., S.E., Washington, D.C. 20201, o comunicarse al 1-877-696-6775.

ALGUNAS DE NUESTRAS OBLIGACIONES Y COMO LAS CUMPLIMOS

Las reglas federales de privacidad de información de salud requieren que le informemos sobre nuestras prácticas de privacidad. Este documento es nuestra notificación. Cumpliremos con las normas de privacidad fijadas en esta notificación. Sin embargo, nos reservamos el derecho de cambiar esta notificación y nuestras prácticas cuando la ley lo permita o requiera. Si cambiamos nuestra notificación de prácticas de privacidad, le proveeremos una revisión en su próxima visita para tratamiento con nosotros.

CUMPLIMIENTO CON CIERTAS LEYES ESTATALES

Cuando usamos o divulgamos su ISP según descrito en esta notificación, o cuando usted ejerza ciertos de sus derechos establecidos en esta notificación, podríamos aplicarle las leyes estatales aplicables a información de salud confidencial en vez de las leyes federales. Hacemos esto cuando las leyes estatales proveen más derechos o protección a su ISP. Por ejemplo, algunas leyes estatales que aplican a información de enfermedades mentales requieren su autorización específica antes que su ISP puede ser divulgada en respuesta a un subpoena. Otra ley estatal nos prohíbe divulgar copia de su información hasta que le hayan dado de alta del hospital. Cuando las leyes estatales no están en conflicto o estas leyes no le ofrecen mejores derechos o mayor protección, continuaremos protegiendo su privacidad aplicándole las reglas federales.

FECHA DE EFECTIVIDAD:
Esta notificación tiene efecto a partir del 14 de July de 2003 Version E1108035)

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)

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

CL0040

Receipt of Notice of Privacy Practices

40-100 (4/15)

Patient Label

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. _____ Initials

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 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 preexisting 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 The George Washington University 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 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

Unable to sign
( ) Serious Condition
( ) _____

_____ _____ _____ _____
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 _____

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

CO4000

PATIENT AUTHORIZATION FORM

80-010 (07/15)

Patient Label

THE OUTPATIENT REHABILITATION CENTER
2131 K STREET NW • SUITE 620 • WASHINGTON, DC 20037
OFFICE#: 202-715-5655 FAX#: 202-715-5664
Patient Registration Form

PLEASE COMPLETE:

PART 1 - PATIENT'S INFORMATION

PATIENT'S LAST NAME	FIRST	MIDDLE	DATE OF REGISTRATION

HOME ADDRESS	APT. NUMBER/P.O. BOX

CITY	STATE	ZIP CODE	HOME TELEPHONE	WORK TELEPHONE

PATIENT'S OCCUPATION	EMPLOYER	WORK ADDRESS

PATIENT'S SEX	BIRTH DATE (Mo./Day/Year)	PATIENT'S SOCIAL SECURITY NUMBER	MARITAL STATUS
☐ MALE ☐ FEMALE	/ /		☐ S ☐ M ☐ SEP ☐ D ☐ W

PART 2 - EMERGENCY CONTACT INFORMATION

NEXT OF KIN OR EMERGENCY CONTACT	HOME TELEPHONE	WORK TELEPHONE
	( )	( )

ADDRESS (STREET, CITY, STATE)	ZIP CODE	RELATIONSHIP TO PATIENT

NAME OF REFERRING PHYSICIAN (IF APPLICABLE)	PHYSICIAN'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

DR.:	**DX.:**

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:_____

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

Outpatient Rehab
Patient Registration

80-647 (05/15)

Patient Label

OUTPATIENT REHABILITATION CENTER

2131 K STREET NW, SUITE 620 • WASHINGTON, DC 20037 • OFFICE #: 202-715-5655 FAX #: 202-715-5664

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:_____

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

HP0010

OUTPATIENT REHABILITATION CENTER

Health History Form/ Subjective Information

80-646 (5/15)

Patient Label