The GWUH Outpatient Rehabilitation Center
2131 K St. NW, Washington, DC 20037 | Tel (202) 715-5655 Fax (202) 715-5664

Welcome to our practice!

Things you need to know

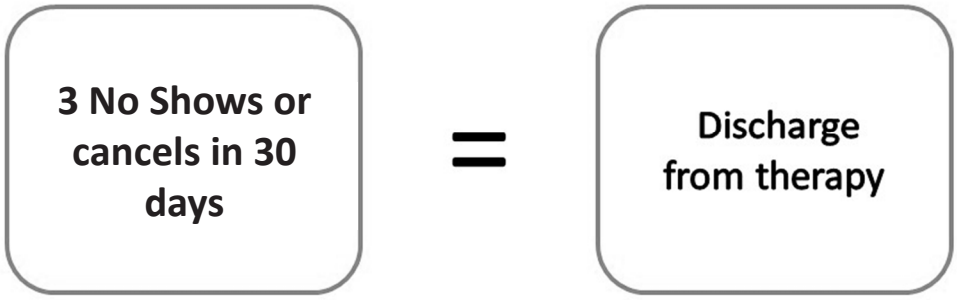
- You can always call 202-715-5655- and press option 2, to make, change, or cancel an appointment.
- Appointments are usually 30- 60 minutes.
- You will **need a prescription** from your doctor for insurance purposes.
- If it's been more than 30 days since your last visit, you might need a new prescription. Check with your therapist!

Attendance is important to your progress!

Attendance Policy

- If you need to cancel, call 202-715-5665, option 2 more than 24 hours before your appointment.
- To cancel through your automatic reminders, please cancel the same day you receive the reminder.
- If you are more than 15 minutes late, we might not be able to accommodate you, and this would count as a no show.

We consider less than 24 hours' notice a no-show, and our policy works like this:



Insurance

- It is your responsibility to know your insurance coverage and your financial obligation. The best way to do this is to contact your insurance company directly.
- If you have any questions about a bill, please call our billing department at 202-715-4905.

By signing this, I confirm that I understand these policies! Thank you.

Signature _____ Date _____

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

CO4000

Outpatient Rehabilitation Attendance and Info Sheet with Signature

76-256 (4/20)

Patient Label

Treatment Authorization

As the individual who will be receiving services at _____ (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 Treatment Authorization 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.

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

Physician Providers Are Not Hospital Employees

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

Personal Valuables

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

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 treatment authorization and am duly authorized to execute the above and accept its terms.

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

_____	_____
Patient/Authorized Signature	Date/Time
_____	_____
Witness Signature	2nd Witness Signature for Verbal Consent

Assignment of Benefits and Financial Responsibility

As the individual who will be receiving services at _____ (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.

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

DOB: SX:
MRN:

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 _____

_____

Patient Identification

DOB: SX:
MRN:

The GWU Outpatient Rehabilitation Center | Pelvic Floor Intake Form

Chosen Name: _____ Birthdate: ____/____/____ Referring Provider: _____

Age: _____ Pronouns: _____

I identify my gender as (please circle): Man | Woman | Trans Man | Trans Woman | Genderqueer/Non-binary | ☐ _____

Current History

Please describe what brings you to pelvic health therapy today: _____

_____

When did your symptoms start? _____

What treatments have you had for your symptoms (i.e.: meds, injections, acupuncture, self-help)?

_____

I would feel better if I could _____

Pain: please rate your pain using a 0-10 scale (0=no pain, 10 = most severe pain you can imagine): On a good day: _____ On a bad day: _____

Where is your pain in your body? _____

What makes your symptoms better? _____ What makes your symptoms worse? _____

Sexual Health	**Bladder/Bowel**
Do you have pain with sex? ☐ Yes ☐ No Contraception type (if applicable), and # years using: _____	Do you leak urine? ☐ Yes ☐ No Do you have any bowel leakage? ☐ Yes ☐ No Activities that cause urine leakage: _____ Do you have a strong sensation when you need to urinate? ☐ Yes ☐ No During the day, at about what interval do you urinate? (Every hour, 2 hours, etc.) _____ How many times do you wake up at night to urinate? _____

Medical History (circle all that apply)

Diabetes | High Blood Pressure | Migraines | Cancer | Kidney Disease| Arthritis | Osteoporosis | Stroke | Currently Pregnant | Fibromyalgia | C-Diff | MRSA | Hearing Impairment | None | TB Positive | Immunocompromised | Active Shingles |
Other: _____

Please provide your **pregnancy/birth history** if applicable: (number/vaginal vs. C-section, any complications?): _____

Surgeries (circle all that apply)

Bowel/Rectal | Gynecological | C-section | Prostate | Abdominal | Other (please specify) _____

Medications (anything you take regularly, including supplements):

_____

Allergies: (food, latex, drug): _____

Social History

What is your occupation? _____

Are you currently working? _____

List your leisure activities (include exercise and hobbies): _____

Have you ever been the victim of emotional, physical or sexual abuse? ☐ Yes ☐ No

Are you anxious? ☐ Yes ☐ No Are you depressed? ☐ Yes ☐ No Do you have a history of anxiety or depression? ☐ Yes ☐ No

What are the main sources of stress in your life? _____

Is there anything we haven't asked you that you'd like to tell us? _____

Thank you for helping us help you!

Patient Signature: _____ Therapist Signature: _____

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

HP4016

Pelvic Floor Intake Form

76-254 (4/20)

Patient Label

The GWU Outpatient Rehabilitation Center

Patient Registration Form

Patient Information				
Last name (as it appears on your official ID)	First Name	Middle Name	Date / /	
Home address				
City	State	Zip Code	Cell Phone	Home Phone
Sex on file with insurance	Birth date / /		Referring Physician	
Email				

Emergency Contact Information		
Emergency Contact/Relationship to Patient	Best Telephone	Alternate Telephone

Primary Language: ☐ **English** ☐ **Spanish** ☐ **Amharic** ☐ **Arabic** ☐ **Other:** _____

Automatic Appointment Reminders **How would you prefer to receive appointment reminders? (Choose one)**		
Phone Call	☐	
Text Message	☐	(please make sure your cell phone is provided)
Email	☐	(please make sure your email is provided above)
No reminders please	☐	

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

EL4000

Outpatient Rehabilitation Registration Form

76-258 (4/20)

Patient Label

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

UHS Universal Health

CL0040

Receipt of Notice of Privacy Practices

40-100 (09/12)

Patient Label

Notice of GWUH's Participation in CRISP

CRISP, the Chesapeake Regional Information System for our Patients, Inc. is a Health Information Exchange (HIE) originally started in the state of Maryland and recently expanded to include the District of Columbia.

CRISP takes patient privacy very seriously and recognizes that HIE cannot succeed if patients do not trust that their information is safe. Protecting patient information in the CRISP HIE is a priority. CRISP follows all State, District and Federal laws (for example HIPAA) to protect patient information.

The George Washington University Hospital has chosen to participate in CRISP. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions.

Your signature indicates that you were notified of GWUH's participation in the CRISP Health Information Exchange:

Patient or Authorized Representative Signature	**Date**
Hospital Representative	**Date**

- **You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at: www.crisphealth.org**

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

UHS Universal Health

CL0040

CRISP Participation Notice

90-905 (11/13)

Patient Label