MossRehab
EINSTEIN HEALTHCARE NETWORK

MossRehab Aphasia Center (MRAC)
New Member Registration - General

VERY IMPORTANT:

FOR PRIVACY PURPOSES
DO NOT SEND THIS PACKET ELECTRONICALLY without talking to MRAC first!

Please print, complete, and POSTAL MAIL these forms to:
MossRehab Aphasia Center
50 Township Line Rd
Elkins Park, PA 19027

If you'd like to make different arrangements:
Call 215.663.6344
Everything must be sent safely and securely.

MossRehab
EINSTEIN HEALTHCARE NETWORK

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New Member Registration - General

Member Information

Name: _____, Date of Birth _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #_____, Email: _____

Emergency Contact/Co-Member Information:

Name: _____ Relationship: _____

Phone # _____, Email: _____

You may also communicate with these people about me:

Name	Relationship	Phone	Email

Aphasia Information

Cause of Aphasia: _____ Date of Onset/Diagnosis: _____

Were you a patient at Moss? Yes ____ No ____, If no, where? _____

Where did you receive speech-language therapy?_____

Most recent Speech-Language Pathologist: Name: _____, Phone # _____

Are you currently receiving speech-language therapy? _____ Yes _____ No

Who referred you to Moss? Name: _____, Phone # _____

Do you have difficulty hearing? Yes____ No____

If yes, do you wear a hearing aid? Yes____ No____

Do you have problems with vision? Yes____ No____

If yes, do you wear glasses? Yes____ No____

Do you have any history of seizures? Yes____ No____

If yes, when was the last seizure? Date _____

Primary Physician: _____ Phone #_____

Member Signature (or initial): _____ Date: _____

Person who assisted in completing this document (if necessary):

_____

Print Signature Date

MossRehab
EINSTEIN HEALTHCARE NETWORK

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INFORMATION AND RELEASE FOR ALL ACTIVITIES

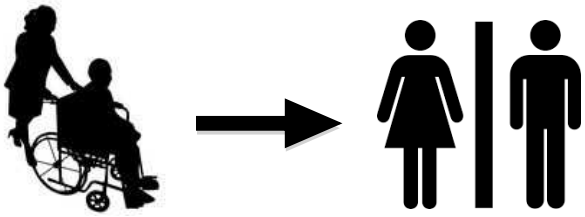
I, _____(print name), understand that

1) Registration and payment should be received by TBD. Check or money order should be made payable to: **Moss Rehab Aphasia Center**.
   Send payment to: MossRehab Aphasia Center
   50 Township Line Road, Suite 304
   Elkins Park, PA 19027

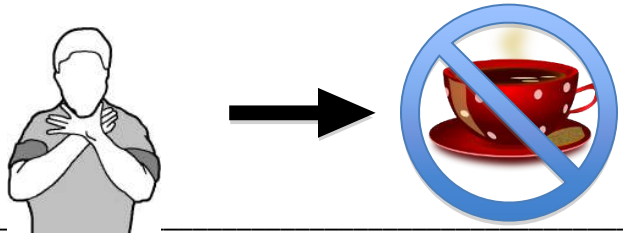
2) Classes are filled on a first come, first served basis. If classes are not full, you can sign up after a session is started and your fee will be pro-rated.

3) Personal absences cannot be made up. If the Activities Center cancels a class, it will be made up. You will be notified by phone if class is cancelled. If area school systems are closed, the Activities Center will be closed for in person activities.

4) You must be independent in your wheelchair or walking. This includes transferring, toileting and using any of your equipment (for example: home oxygen). You can participate if you are not independent but you must bring someone with you to the sessions to assist you.



5) We offer refreshments.
   If you have swallowing difficulties or dietary restrictions, you must be able to manage them independently, or bring someone with you to assist you.



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6) We do not expect there to be risks involved in participating in these activities, other than those of daily life.

7) MossRehab Aphasia Center maintains privacy and confidentiality of members.

8) MossRehab cannot control what other group members do with information shared during group activities.

9) Anyone who has had aphasia for 6 months or more may participate. You may be asked to provide a recent speech report, have your doctor or speech pathologist contact Sharon Antonucci at (215) 663-6561**,** or meet Activities Center staff to decide on group placement.

   For other information, please call Nikki Benson at (215) 663-6344.

10) Participation in the activities center is voluntary. The Activities Center offers social, recreational, and educational activities. Participation is not considered "skilled care" per Medicare and Medicaid guidelines, and as such is not covered by insurance.

Signature: _____ Date: _____

Person who assisted in completing this form (if applicable):

_____

MossRehab
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New Member Registration - General

Print Signature Date

MRAC ACTIVITY SELECTION

All Checks Payable to: MossRehab Aphasia Center

CONSTANCE SHEERR KITTNER CONVERSATION CAFÉ: Yes_____ No____
$115 (Virtual) or $125 (In Person)/10 Weeks

Do you want to have some fun while you tune up your communication skills? Then join one of Connie's Cafes, a conversation group for people living with aphasia.

Many people with aphasia and their families report feeling socially isolated and misunderstood. By joining a conversation cafe, you will have the opportunity to have your voice heard in a supportive environment. Our goals are to provide opportunities for adult conversation and social interaction, to encourage the use of successful communication strategies and to share "recipes for success" in dealing with aphasia and enjoying life.

New members will be assigned to a group depending on communication needs and available space. Karen R. Cohen, Speech-Language Pathologist at the Aphasia Center will facilitate and coach these sessions.

RETA'S GAMES GROUP PRESENTS: Yes _____ No_____
MRAC VIRTUAL VARIETY HOUR:
No Charge/ Year Round

Do you like to play games? Rummy? Jeopardy? Word Games? Sing? Would you like to learn how? Come join us for games and use your communication skills while having fun. Our volunteer leader will help you get started or partner with you until you catch on to the game. I am interested in joining Reta's Games Group.

NOTE FOR IN PERSON SESSIONS: You must be independent in your wheelchair or walking. This includes oxygen). You can participate if you are not independent, but you must bring someone with you to the sessions to assist you

MossRehab
EINSTEIN HEALTHCARE NETWORK

MossRehab Aphasia Center (MRAC)
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MRAC ACTIVITY SELECTION

All Checks Payable to: MossRehab Aphasia Center

COMPUTER LAB: Yes_____ No____
$50 initial session/$25 each additional session

Do you want to have some fun while using aphasia practice apps? Learn how to Zoom, use your smart phone, send emails, search the internet, or anything 'techie'?

Computer technology has the potential to reduce barriers to communication, improve skills and quickly connect people to information and social networks. In our computer lab, individuals who have completed speech therapy and have targeted self-study goals work to use specialized aphasia software (e.g., Tactus Therapy, LIngraphica TalkPath, and SentenceShaper™) and refresh their computer, tablet or smartphone skills so they can email with family and friends, or connect through social media. These efforts are aimed at helping people with aphasia to maximize their communication skills and social interaction and to promote self-learning.

New members will have an initial session to review their skills and goals.
Dr. Sharon Antonucci, or a trained volunteer at the Aphasia Center, will facilitate these sessions.

NOTE FOR IN PERSON SESSIONS: You must be independent in your wheelchair or walking. This includes oxygen). You can participate if you are not independent, but you must bring someone with you to the sessions to assist you

MossRehab
EINSTEIN HEALTHCARE NETWORK

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ACTIVITY REGISTRATION SELECTION

All Checks Payable to: MossRehab Aphasia Center

TALKING BOOK CLUB: Yes _____ No_____

Cost: $125.00 (Virtual) $150.00 (In Person)

Would you like a supportive group to read and talk about books with? Then join our talking book club. I am interested in joining MRAC's Talking Book Club.

Gather for weekly sessions where our SLP shares a preview outline of the chapters and characters you'll meet during the week's assigned chapters; then read and/or listen along with the book on tape* as you need; then return the following week to discuss and get the next week's notes. Books are selected by the group.

*The book on tape can be provided at no additional charge though joining the BARD library. Ask for further details.

Karen R. Cohen, Speech-Language Pathologist at the Aphasia Center will facilitate and coach these sessions.

Please tell us about your reading:

BEFORE my stroke, I enjoyed reading books _____, magazines _____, newspapers _____, other (please list) _____.

NOW I read: Not at all ____, words ____, sentences ____, paragraphs ____, books ____, magazines ____, newspapers ____, other (please list)_____.

NOTE FOR IN PERSON SESSIONS: You must be independent in your wheelchair or walking. This includes oxygen). You can participate if you are not independent, but you must bring someone with you to the sessions to assist you.

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About Me

Please complete and return with registration.

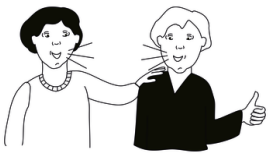
Name: _____

These are the top 3 things I want people to know about me:

My main challenges or frustrations related to aphasia:

_____
_____
_____
_____

Things that help me or make me feel better:



_____
_____
_____
_____

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People

Please include as many people as you might like to talk about (children, grandchildren, friends, family, etc.). Use the backside of the paper if you like.

Person:	Relationship to you:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Work

What type of work do/did you do?

Where do/did you work?

Were you retired at the time of you received a diagnosis of aphasia?

Yes_____ No_____

Hobbies

Hobbies or interests <u>before</u> aphasia:

Hobbies or interests <u>after</u> aphasia:

MossRehab Aphasia Center (MRAC)
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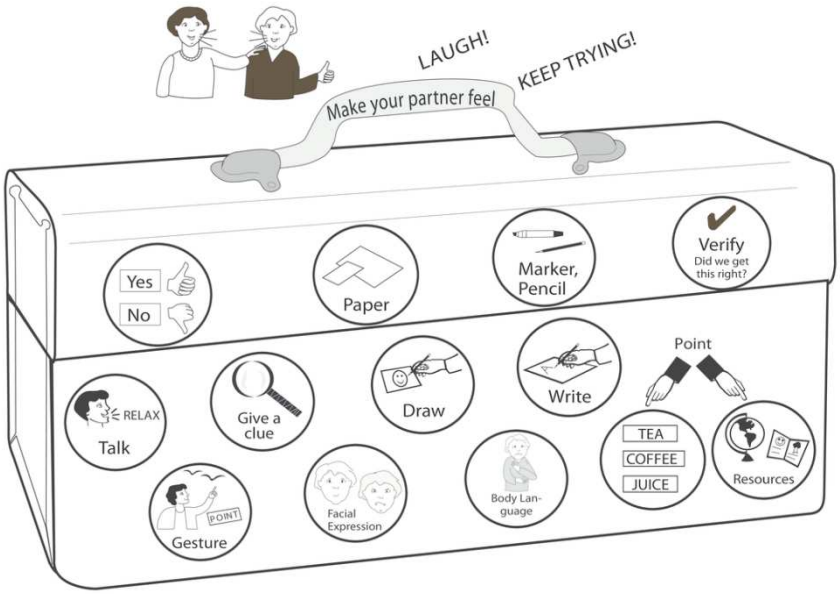
Communicating

Do you talk often at home? Yes_____ No_____

How do you communicate at home? (Circle all that apply)



Goals

What are your goals for joining the Aphasia Center?

Is there anything specific you'd like to work on or practice?

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PATIENT AUTHORIZATION
FOR EMAIL COMMUNICATION

PLEASE SELECT YOUR COMMUNICATION PREFERENCES BELOW.

PROVIDER (MRAC) COMMUNICATION PREFERENCE:

☐ I,_____ do NOT wish to communicate with my provider via email. I will use phone and US Mail systems only. I understand that this is a slower process and I may miss deadlines or opportunities as a result of unforeseen delays outside of MRAC's control.

☐ I,_____ wish to communicate with my provider via email. Patient/family member should initial next to each statement:

___ I understand that email communications and this authorization form will be filed in my permanent medical record.

___ I agree to use email for nonemergency purposes only.

___ I agree to inform this office in writing if my email address changes.

GROUP COMMUNICATION PREFERENCE:

☐ I,_____ do NOT wish to communicate with my group outside of our scheduled sessions.

☐ I,_____ would enjoy communing with my group outside of sessions. It is okay to share my: ☐ email ☐ phone #

My current email address: _____

My current phone number: _____ Date: _____

Signature: _____

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Public Relations & Marketing Authorization to Use & Disclose Protected Health Information

Individual's Name: _____
Last Name First Middle

Mailing Address: _____

_____

Home Telephone: _____ Date of Birth: _____

INFORMATION TO BE DISCLOSED:

- ❑ General information regarding medical condition, treatment and outcome
- ❑ Other _____

_____

AUDIOVISUALS TO BE RELEASED:

- ❑ Photography Videotape Audio tape
- ❑ Other: _____

PURPOSE: I give Einstein Healthcare Network permission to use or disclose (give out) my protected health information, as indicated above, for public relations and/or marketing purposes. I understand that the information may be used by Einstein Healthcare Network and its Corporate Marketing and Communications Department, the news media and any other medium of communications (including newspapers, magazines, television, radio, pamphlets, brochures, reports, websites/social media, etc). In addition, audiotape, photographs, videotape or other recorded images may be used, as indicated above.

(Continued on Reverse Side)

MossRehab
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TERM: I understand that this Public Relations and Marketing Authorization will remain in effect until I take back (revoke) my permission by writing to the Einstein's Privacy Office at the address listed below. The revocation will take effect as soon as Einstein receives my written notice. However, the revocation will not affect any uses or disclosures of information that were made based on your prior authorization.
I understand that I may refuse to sign or may revoke (at any time) this Public Relations and Marketing Authorization for any reason and that such refusal or revocation will not affect the start, continuation or quality of my treatment at Einstein.

I may contact Einstein's Privacy Office by mail at Einstein Healthcare Network, Gratz Building, 1000 West Tabor Rd, Philadelphia, PA 19141; by telephone at (215) 456-0485; or by email at privacy@einstein.edu.

I have read and understand the terms of this Public Relations and Marketing Authorization, and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Einstein to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Public Relations and Marketing Authorization, obtain the following signatures:

_____	_____	_____
Signature of Personal Representative	Description of Authority	Date

Project manager: _____

Project name or job number: _____

Date scanned/filed into permission archives: _____ By (initials): _____

MossRehab
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MRAC ANNUAL EMERGENCY CONTACT SHEET

Please provide the following information. Emergencies can happen when we are in person or virtual.

We will check in annually in case there are updates.

Please be sure to complete all the information in bold.
Thank you. ☺

Member Name: _____

Member Phone: _____

Member Email: _____

Member Physical Address: _____

_____

Emergency Contact 1 Name/Relation: _____

Emergency Contact 1 Phone: _____

Emergency Contact 2 Name/Relation: _____

Emergency Contact 2 Phone: _____

CURRENT CALENDAR YEAR: _____

Joint Notice of Privacy Practices

This Notice of Privacy Practices ("Notice") describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date: April 14, 2003
Revision Date: June 23, 2016

This Notice of Privacy Practices identifies the general ways your Protected Health Information (PHI) can be used or disclosed by **EINSTEIN HEALTHCARE NETWORK ("EINSTEIN")**, which is identified for purposes of federal privacy requirements as an Organized Healthcare Arrangement. The organizations listed below use PHI about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. "PHI" is the individually identifiable personal health information found in your medical and billing records. This information can be transmitted or maintained in any form by EINSTEIN. This Notice describes your legal rights regarding your protected health information. It also informs you of the legal duties and privacy practices of EINSTEIN.

For the purpose of this Notice, the terms "you" or "your" refers to the patient who is the subject of the protected health information. The terms "we", "our" or "us" refers to EINSTEIN.

ORGANIZATIONS COVERED BY JOINT NOTICE

This Joint Notice describes the privacy practices of EINSTEIN, a Pennsylvania nonprofit corporation, its affiliated entities, divisions, programs, departments and units, including, but not limited to:

Albert Einstein Medical Center

- Einstein Medical Center Philadelphia
- Einstein Medical Center Elkins Park
- MossRehab
- Willowcrest
- Einstein Center One
- Einstein Medical Center Montgomery
- Einstein Practice Plan, Inc. (doing business as "Einstein Physicians")
- Einstein Community Health Associates, Inc. (doing business as "Einstein Physicians")
- Fornance Physician Services (doing business as "Einstein Physicians Montgomery")

OUR LEGAL DUTIES

We are required by law to keep your identifiable PHI private, provide you with this Notice of our legal duties and privacy practices with respect to your protected health information and follow the terms of this Notice as long as it is in effect. If we revise this Notice, we will follow the terms of the revised Notice, as long as it is in effect.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following information describes how we are permitted, or required by law, to use and disclose your protected health information. Not every use or disclosure in a category will be listed.

Treatment: We may use or disclose your PHI to a physician or other health care provider in order to provide care and treatment to you. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose PHI about you to those who may be involved in your health care outside of EINSTEIN, such as hospitals, physicians and others who provide you with follow-up care and medical equipment or product suppliers. We may contact you to provide appointment reminders and to provide you with information about health-related benefits and services provided by us, or treatment alternatives that may be of interest to you.

Payment: We may use or disclose your PHI to obtain payment for services we provide to you. We may disclose your PHI to another health care provider or entity. For example, we may need to provide your health plan with information about surgery you received so your health plan will pay us or reimburse you for the surgery. We'll also tell your health plan about a treatment you are going to receive to obtain the health plan's prior approval for this treatment or to determine whether your plan will cover the treatment.

Health Care Operations: We may use or disclose PHI about you to support the programs and activities of EINSTEIN such as quality and service improvement, health care delivery review, regulatory compliance, staff performance evaluation, competence or qualification review of health care professionals, education and training of physicians and other health care providers, business planning and development, business management and general administrative activities. We use this information to continuously improve the quality of care for all patients we serve. For example, we may combine PHI about many patients to evaluate the need for new services or treatments. We may disclose information to doctors, nurses, and other students for educational purposes. We may also combine PHI we have with that of other facilities to see where we can make improvements.

Additionally, we may share your PHI with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your protected health information.

Health Information Exchange (HIE): As a member with HealthShare Exchange of Southeastern Pennsylvania, Inc., (HSX) we may use or disclose your PHI to this Health Information Organization (HIO) and also to the HIO of the Commonwealth, The Pennsylvania Patient and Provider Network (P3N). Other health care providers, such as physicians, hospitals and other health care facilities, may have access to this information for treatment, payment and other purposes, to the extent permitted by law. More information can be obtained by visiting http://www.hsxsepa.org.

You have the right to "opt-out" or decline to participate in the Health Information Exchange (HIE). If you choose to opt-out of the HIE, we will not use or disclose any of your information in connection with HSX or P3N. To opt out of HSX go to http://www.hsxsepa.org/patient-options-opt-out-back or call 215-391-4906.

Authorization for Other Disclosures: We will not use or disclose your protected health information, except as described throughout this document, unless you authorize us, in writing, to do so. You can revoke an authorization at any time, in writing. If you revoke an authorization, we will no longer use or disclose your PHI for the purpose covered by the authorization. However, we are unable to take back any uses or disclosures already made with your authorization. Specific examples of uses or disclosures requiring authorization include: use of psychotherapy notes, marketing activities, the sale of your PHI and most non-treatment uses and disclosures for which we are compensated and for any other uses and disclosures of PHI not described in this Joint Notice of Privacy Practices.

Family and Friends: We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or other person responsible for your care, of your location and general condition. We will also disclose PHI to a family member, other relative, close personal friend, or any other person you identify, if the information is relevant to that person's involvement with your care or payment for your care. You can prohibit disclosure of this information.

Fundraising: We may contact you for EINSTEIN fundraising efforts, but you can tell us not to contact you again.

To Stop Receiving Fundraising or Marketing Materials:

You may request that your name be removed from our fundraising and marketing lists. Please contact our fundraising office at 5501 Old York Road, Philadelphia, PA, 19141 or call 215-456-7200. Contact our Marketing office at 101 E. Olney Avenue, Suite 503, Philadelphia, PA 19120 or call 1-800-EINSTEIN.

Marketing Activities: Written authorization is required prior to using or disclosing your PHI for marketing activities that are supported by payments from third parties.

Your written authorization is not required in the following circumstances:

(1) EINSTEIN receives no financial compensation for making the communication;

(2) the communication is face-to-face or consists of a promotional gift of nominal value provided by EINSTEIN;

(3) communications about a drug or biological or refill reminders for medication that the patient is currently taking/being prescribed;

(4) communications that involve general health promotion, such as community events, health screenings

(5) communications about case management and helping you find a physician, rather than the promotion of a specific product or service;

(6) communications encouraging routine diagnostic tests; and

(7) communications about government and government-sponsored programs.

Future Communications: We may use or disclose your information to communicate with you via newsletters, mailings, emails, SMS(text messages) or other electronic means regarding treatment options, health related information, disease-management programs, wellness programs or other community based initiatives or activities in which we participate. If we receive any financial compensation for such communications (with limited exceptions), we will obtain your authorization prior to sending the communication and your authorization can be revoked at any time.

Public Health and Safety: We may use or disclose your protected health information, as authorized or required by local, state or federal law, for the purposes deemed to be in the public interest or benefit. For example,

- To report certain diseases and wounds, births and deaths, and suspected cases of abuse, neglect or domestic violence;
- To help identify, locate or report criminal suspects, crime victims, suspicious deaths or criminal conduct on the premises of EINSTEIN;
- To respond to a court order, subpoena or other judicial process;
- To assist federal disaster relief efforts;
- To enable product recalls, repairs or replacements;
- To respond to an audit, inspection, or investigation by a health-related government agency;
- To assist in federal intelligence, counterintelligence and national security issues;
- To facilitate organ and tissue donations;
- To assist coroners, medical examiners and funeral directors;
- To respond to a request from a jail or prison regarding an inmate's health or medical treatment;
- To respond to a request from your military command authority (if you are a member or veteran of the armed forces);
- To comply with laws and regulations related to workers' compensation.

Other Uses. Other uses and disclosures will be made only with your written authorization.

Business Associates: There are some services provided at EINSTEIN through contracts with business associates. When these services are contracted, we may disclose your PHI to the business associate so they can perform the job we have asked them to do. However, business associates are required by federal law to appropriately safeguard your information.

Research: We will disclose information to researchers after approval by an Institutional Review Board (IRB) in preparation for a research study, to recruit research subjects or for a research study. The IRB reviews research proposals and establishes protocols to protect your safety and the privacy of your protected health information.

Confidential Communications: You have the right to request that we communicate PHI to you by an alternate means or location other than your home address and telephone number. Your request must be made in writing to us, and must specify how or where you wish to be contacted. We will try to accommodate your request for alternate communications. If you request an alternate means of communication, that request should also be communicated by you to each of your physicians.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:

Restrictions: You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. To request a restriction, you must make your request in writing to the listed contact person. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Additionally, you have the right to request that we not use or disclose your PHI to a health plan for purposes of payment or health care operations (not for treatment) if the information pertains solely to a health care item or service that has been paid for out-of-pocket and in full. Your request for restriction must be submitted in writing to us. In this case, we must honor your request. However, you should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

Access: You have the right to review and obtain a copy of your health information, with certain exceptions. Usually, this includes medical and billing records, but does not include psychotherapy notes. Your request to review or obtain a copy of your health information must be in writing to our listed contact person. You will be charged fees as authorized by law. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Amendment: If you feel that the health information we have about you is incorrect or incomplete, you have the right to ask for an amendment of that information. You have the right to request an amendment for as long as the information is kept by or for us. Your request for an amendment must be made in writing to our listed contact person and include a reason that supports your request. We do not have to honor your request but will advise you of our decision in writing.

Accounting of Disclosures: You have the right to receive a list of certain disclosures of your PHI that we have made within the last six years. Your request for an accounting must be in writing to our listed contact person, and must state a time period for which you want an accounting. You may request one accounting free of charge within a 12-month period. A fee will be charged for additional lists within this same time period.

Breach Notification: In certain instances, you have the right to be notified in the event that we, or one of our Business Associates, discover an inappropriate use or disclosure of your protected health information. Notice of any such use or disclosure will be made in accordance with state and federal requirements.

Copy of Notice: You have the right to a paper copy of this Notice. In addition, a copy of this Notice also may be obtained at our Website, http://www.EINSTEIN.edu/patients-visitors/for-patients/patient-support-services/notice-of-privacy-practices/.

Revisions of this Notice: We reserve the right to change this Notice, and the right to make the new provisions effective for all health information we currently maintain, as well as any information we receive in the future. If we make a major change to this Notice, the revised Notice will be posted in EINSTEIN's place of business and on its Website. In addition, a paper copy of the revised Notice will be available upon request.

To Report a Complaint: If you believe your PHI privacy rights have been violated, you can file a complaint with us by mail, at the address provided in this Notice. You may also file a complaint with the Secretary of the United States Department of Health and Human Services, Office of Civil Rights, by completing a Health Information Privacy Complaint Form (available at http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf) and sending it to the applicable OCR Regional Office listed on the form, or by calling 1-800-368-1019 for instructions and contact information. There will not be any penalty or retaliation against you for making a complaint to us or to the Department of Health and Human Services.

Contact Person: If you have any questions or need information regarding our legal duties and privacy practices, or how to exercise any of your PHI rights listed in this Notice, or need assistance with exercising your right to "opt-out" from any disclosure, please contact: Chief Information Security and Privacy Officer, EINSTEIN Healthcare Network Gratz Building, 1000 W. Tabor Road Philadelphia, PA 19141; Telephone: 215-456-3517; E-mail: Privacy@EINSTEIN.edu

NOTE: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specific PHI may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosure of these types of records will be subject to these special protections.

Einstein
HEALTHCARE NETWORK
More than Medicine

Einstein Healthcare Network

Patient Label (All Entries Must Have Date & Time)

Notice of Privacy Practices

Acknowledgment and Authorization

By signing below, I acknowledge that I have received Einstein Healthcare Network's Notice of Privacy Practices and I authorize Einstein Healthcare Network to use, access and disclose my health information in the manner described in this Notice.

Name (please print): _____

Signature: _____

Date: _____ Time:_____

For Einstein Staff Use Only

Inability to Obtain Acknowledgment

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the reasons why the acknowledgment was not obtained:

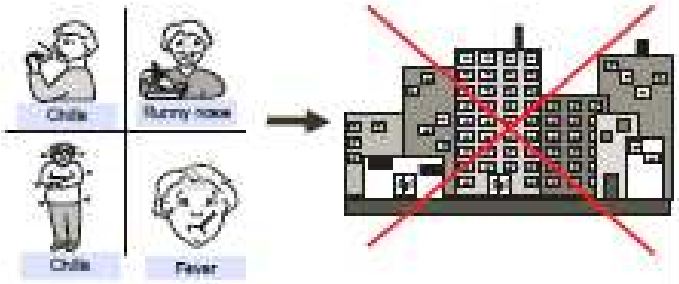
- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other (Please specify):_____

Name of Einstein Representative (please print): _____

Date: _____ Time:_____

MRAC Online Consent

Due to COVID-19 our building is closed



We want to keep connected
We will be offering programs and groups online

Potential Benefits

✔ Stay in touch

✔ Participate in programs and services

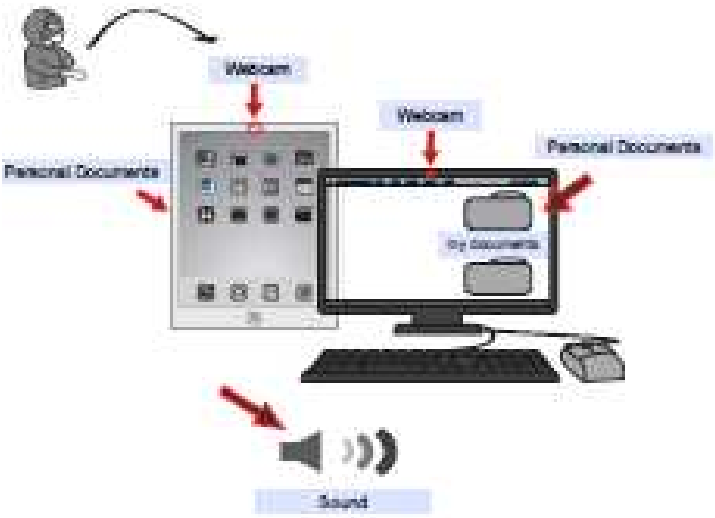
Potential Risks

✘ There is a risk of other people hearing the conversation

✘ There is a risk of someone interrupting the conversation

Potential Risks

✘ There is a risk of someone accessing your ...



We are doing our best to reduce the risks

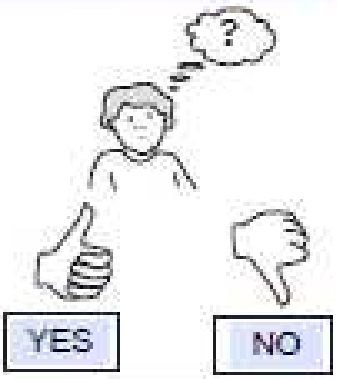
✔ We Zoom with password & waiting room

✔ You can stop at any time

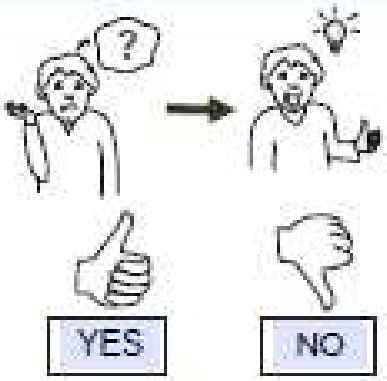
✔ It is your choice

✔ It is ok to stop

Do you have any questions?



Do you understand?



I agree to participate in online programs and groups

YES 

NO 

Participant Name: _____

Signature: _____

Date: _____

Person Assisting with Completing this Document:

Name: _____

Date: _____