MossRehab
EINSTEIN HEALTHCARE NETWORK

MossRehab Aphasia Center (MRAC)
New Member Registration - PPA

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

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

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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: _____

Co-Member Signature (or initial): _____ Date: _____

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INFORMATION AND RELEASE FOR ALL ACTIVITIES

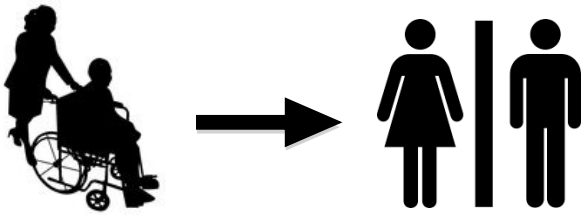
We, _____(print names of member & conversation partner), understand that

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

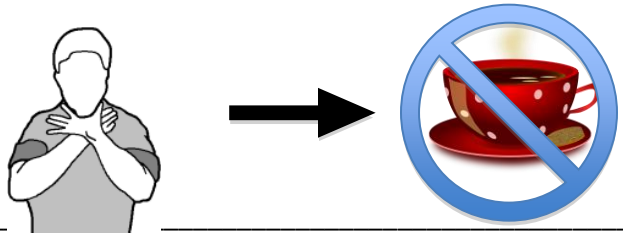
2) Classes are filled on a first come, first served basis. If classes are not full, you can sign up after a session is started and your fee will be pro-rated.

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.

11) There may come a time when participation is no longer appropriate. The Aphasia Center Speech-Language Pathologist will regularly communication with us about ongoing participation.

Member Signature: _____ Date: _____

Co-Member Signature: _____ Date:_____

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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.

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:

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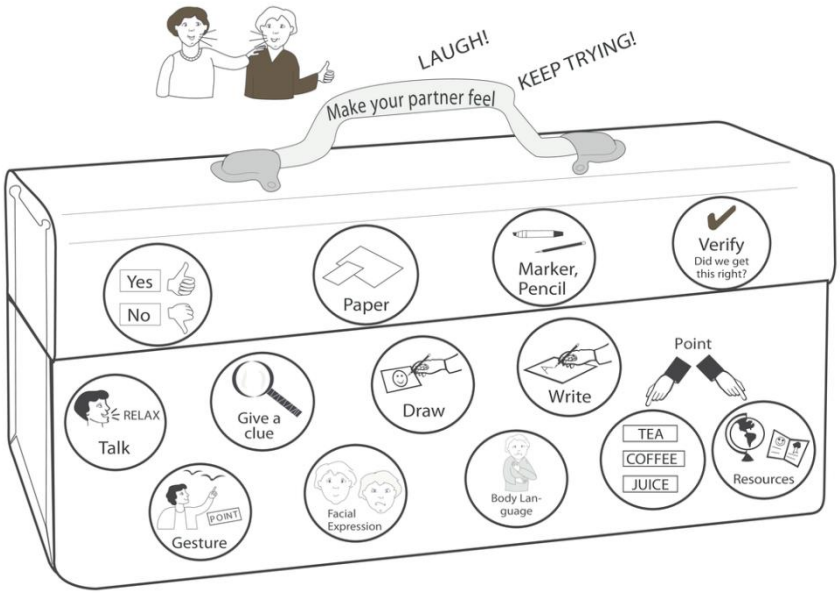
Communicating

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)

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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): _____

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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: _____