MedStar NRH
Rehabilitation Network

# Outpatient Health History (Confidential)

**Patient Name:**
**DOB:**
**EMPI/MRN:**

**Emergency Contact:**_____ **Relationship:**_____ **Phone #:**_____
**Reason for Referral:**_____
**Person Completing form:** _____ ☐ **Patient** ☐ **Other** _____ **Date:**_____

## MEDICAL HISTORY (PLEASE CHECK ALL MEDICAL DIAGNOSIS AND CONDITIONS THAT APPLY)

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chemical Dependency
- ☐ Communicable Disease:
  - ☐ HIV+ ☐ HPV ☐ MRSA
  - ☐ VRE ☐ E Coli ☐ Scabies
  - ☐ Herpes Zoster ☐_____
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Irregular or Rapid Heart Beat
- ☐ Joint Replacement / Metal Implant
- ☐ Kidney Problems
- ☐ Osteoporosis
- ☐ Motor Vehicle Injury
- ☐ Pacemaker
- ☐ Current Pregnancy
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Work Injury

☐ ***Other medical condition if not listed above***: _____

**PAIN:** Do you currently have pain or have you had pain in the recent past? ☐ YES ☐ NO *If Yes, specify*

_____
_____

## DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Productive cough | Yes ☐ | No ☐ | Trouble breathing | Yes ☐ | No ☐ | Constipation | Yes ☐ | No ☐ |
| Fever / Chill | Yes ☐ | No ☐ | Joint pain | Yes ☐ | No ☐ | Bloody Stools | Yes ☐ | No ☐ |
| Coughing up blood | Yes ☐ | No ☐ | Joint stiffness | Yes ☐ | No ☐ | Difficulty or pain with urination | Yes ☐ | No ☐ |
| Night sweats | Yes ☐ | No ☐ | Rashes or skin changes | Yes ☐ | No ☐ | Incontinent bladder | Yes ☐ | No ☐ |
| Nausea / Vomiting | Yes ☐ | No ☐ | Visual changes | Yes ☐ | No ☐ | Incontinent bowel | Yes ☐ | No ☐ |
| Chest pain | Yes ☐ | No ☐ | Hearing changes | Yes ☐ | No ☐ | Other:_____ | Yes ☐ | No ☐ |

**NUTRITION:** Are you concerned about your Nutrition? ☐ Yes ☐ No Have you had an unexplained weight loss? ☐ Yes ☐ No
Have you had an unexplained weight gain? ☐ Yes ☐ No Specify loss or gain: _____lbs

**FALLS:** Are you concerned about falling? ☐ Yes ☐ No Have you fallen in the last year? ☐ Yes ☐ No If yes, Date: _____
Have you fallen more than 2 times? ☐ Yes ☐ No Has any fall resulted in injury? ☐ Yes ☐ No Specify:_____

**IMMUNIZATION:** **(For Pediatric Patients Only) Check (✓) if you have been immunized for the following:**
DPT (Diphtheria,Pertussis,Tetanus) ☐ Yes ☐ No Chickenpox (Varicella) ☐ Yes ☐ No ☐ MMR (Measles, Mumps, Rubella) ☐ Yes ☐ No

## SURGERIES / HOSPITAL PROCEDURES

_____
_____

## ALLERGIES / DRUG INTERACTIONS

**Many rehab clinic products contain Latex. *Do you have any allergy to Latex?*** ☐ Yes ☐ No

_____

## CURRENT MEDICATIONS (INCLUDE OVER-THE-COUNTER MEDICATIONS AND HERBAL PREPARATIONS)

| Medication Name | Dose | Frequency | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

The information on this form will be reviewed and discussed with the patient, and the information will be incorporated into the treatment goals and plan of care established in collaboration with the patient. Refer to individual service area evaluations and care plans. 2018

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# Notice of Privacy Practices
# Receipt / Waiver Documentation Form

In compliance with federal regulations, we are required to distribute the MedStar "Notice of Privacy Practices" to all patients.

***Option 1:*** **If you wish to receive a printed copy of the privacy practices, please sign below and a Team Member will provide one**.

- I request a printed copy of the MedStar "Notice of Privacy Practices".

_____

Patient Name *(please print)*

_____ _____

Patient Signature Date Received

***Option 2:*** **If you wish to waive receipt of a printed copy of the privacy practices, please sign below.**

- I have been offered the MedStar "Notice of Privacy Practices" and waive receipt of a printed copy.

_____

Patient Name *(please print)*

_____ _____

Patient Signature Date

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Patient Name:

DOB:

EMPI/MRN:

# ATTENDANCE POLICY

Welcome to Medstar NRH Outpatient Services. Our goal is to provide you with the best services to improve your function and reach your therapy goals (PT, OT, SLP) and/or your skills for independent living.

Because we feel consistency is vital to achieve maximum benefit from your therapy, we have initiated the following procedure for appointments & attendance policy. If you will be late, or are unable to attend a session please call _____ promptly to reschedule.

- If you cancel three (3) therapy sessions within one month (a cancel with less than 24 hours notice) you will be discharged from therapy.
- If you miss two (2) therapy sessions in a row and do not call to cancel, you will be discharged from therapy.
- If you miss three (3) therapy sessions at any time during your course of therapy and do not call to cancel those sessions, you will be discharged from therapy.

**** IF YOU NO SHOW OR CANCEL AN APPOINTMENT, WITH LESS THAN 24 HOURS NOTICE, YOU WILL BE CHARGED A $25 FEE FOR THE MISSED VISIT.**

****FOR APPOINTMENTS WITH INTERPRETER SERVICES:** You must cancel all appointments within 48 hour notice. If you cancel less than 48 hours prior to your appointment our site will be subjected to the interpreter fee for that missed session.

Our goal is to help you reach your therapy goals but this can only happen if you have regular attendance. If you have questions or concerns please talk to your therapist. Feel free at anytime to give us your comments or thoughts for improving our services.

**I HAVE READ THE ABOVE INFORMATION AND AGREE TO THE ATTENDANCE POLICY**

Signature:_____ Relationship to patient: _____

Date: _____

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## PATIENT INFORMATION

Welcome to the Medstar NRH Rehabilitation Network. Our healthcare professionals provide patients with state-of-the-art rehabilitation technology, therapeutic facilities and medical expertise. All of our facilities feature open exercise as well as private treatment areas. Whether your objectives are to return to work, leisure or sports related activities, we are committed to providing you with excellence in patient care. Your satisfaction is very important to us. Your feedback assists us with improvements. Please take a moment to complete a satisfaction survey and place in the designated box at your treatment location.

## PATIENT RIGHTS

**As a patient in the Medstar NRH Rehabilitation Network, you have the right to:**

1. Expect considerate and respectful treatment by our staff and other patients regardless of your race, color, national origin, gender, sexual orientation, religious creed, age, disability, handicap or source of payment for care.
2. The most appropriate medical and clinical services regardless of your race, color, national origin, gender, sexual orientation, religious creed, age, disability, handicap or source of payment for care.
3. Understand your diagnosis and treatment, as well as the possible outcomes, risks and benefits of your care, and be informed of unanticipated outcomes if they should arise.
4. Information about the associated risks, probable results and alternatives before consenting to any procedure or treatment.
5. Information about pain, pain relief measures, and to have your pain evaluated and treated by concerned and committed staff.
6. Be free from all forms of abuse, neglect and harassment.
7. Refuse any drug, procedure, or treatment to the extent permitted by law, and to be informed of medical consequences of your actions.
8. Expect your medical care program and records to be treated confidentially.
9. Obtain a copy of the MedStar Health Notice of Privacy Practices.
10. Access all information in your medical records unless restricted by medical reasons or prohibited by law.
11. Information about our teaching programs if you are asked to cooperate in professional education programs. You may refuse to participate in these programs without bias.
12. Information about any relationship we have with other health care and educational institutions as it concerns your care.
13. An explanation of the need for a transfer to another facility. You must first be accepted by the facility before being transferred.
14. Know your rights and what rules and regulations apply to your conduct as a patient at our network.
15. Information about your continuing health care requirements at the time of discharge.
16. Request an interpreter if you do not speak or understand English, or for sign language.
17. Participate in health care decision-making and have an advance directive honored. Please ensure we have a copy of any Advance Directive on file and discuss with your providers of service. For more information about Advance Directives, contact Outpatient Social Work at 202-877-1664.
18. Participate in discussion of any ethical issues that may arise in your care.
19. Expect privacy and security to be maintained by all of our employees and access to protective services.

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## PATIENT RESPONSIBILITY

**The patient has the responsibility to:**

1. Provide complete information about present health complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
2. Cooperate with our personnel working with you and following your recommended treatment plan. Please ask questions if you do not understand any directions given to you.
3. Keep your appointments and notify appropriate staff members if you are unable to do so.
4. Pay bills promptly, obtaining managed care referrals, providing insurance information and asking questions you may have about your bill.
5. Inform your assigned case manager, site administrative manager or clinic director as soon as possible if you believe your rights have been violated.

## QUESTIONS OR CONCERNS

**If you have questions, concerns, comments, or a complaint** please contact the site administrative manager or clinic director. They can assist you with questions and concerns about Network policies, facilitating problem resolution and accommodating any special needs. The Network also has a process to address complaints or grievances through the Office of Customer Service. The site administrative manager can provide more information on this process.

**If you are receiving treatment at our Maryland locations** you may choose to contact the Maryland Department of Health and Mental Hygiene, Office of Healthcare Quality, Spring Grove Hospital Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228, or call (410) 402-8000. **If you are receiving treatment at our D.C. locations,** you may choose to contact The District of Columbia Government, Department of Health, Health Regulation Administration, 825 N. Capital St., N.E. Washington, D.C. 20002 or call the complaint desk at: (202) 442-5833. **If you are receiving treatment at our Virginia locations,** you may choose to contact The Virginia Department of Health, Complaint Unit, at 1-800-955-1819. You may also contact the Joint Commission (JCAHO) by calling: 800 994-6610 or via e-mail at complaint@jcaho.org.

## ATTENDANCE POLICY

In order to successfully achieve the goals of treatment established by you and the healthcare professionals, consistent prompt attendance according to your plan of care is essential. Late arrivals may not receive full treatment. As a courtesy to our clinicians and other patients, we appreciate a telephone call at least 24 hours prior to your scheduled appointment. If you need to cancel, please contact the main telephone number of the facility you are attending.

**Our attendance policy is as follows:**

- If you cancel three (3) therapy sessions within one month (a cancel with less than 24 hours notice) you will be discharged from therapy.
- If you miss two (2) therapy sessions in a row and do not call to cancel, you will be discharged from therapy.
- If you miss three (3) treatment sessions at any time during your course of therapy, and do not call to cancel those sessions, you will be discharged from therapy.
- Once discharged, your upcoming therapy appointments will be cancelled. In order to be readmitted after discharge, you will need to contact your physician to obtain a new therapy prescription. If you receive a new prescription for therapy, we will reschedule your appointments. If you are discharged more than once for non-compliance with this policy, you will not be rescheduled.

## COLLECTION OF PAYMENTS

Co-payments are collected at the time services are rendered at the front desk.

## KEY TELEPHONE NUMBERS AND SITE INFORMATION

- Billing Questions 888-766-1009
- For detailed Outpatient site location information, directions and phone numbers please visit:

www.medstarnrh.org/our-network/locations/