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.
MossRehab Aphasia Center (MRAC)
New Member Registration - PPA

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: ________________

Rev 3/2022 Member Name __________________________
INFORMATION AND RELEASE FOR ALL ACTIVITIES

We, ________________________________________________, 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.
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 communicate with us about ongoing participation.

Member Signature: ________________________________ Date: ________________

Co-Member Signature: ______________________________ Date: ________________

Rev 3/2022 Member Name ____________________________________________________________
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.
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:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Rev 3/2022 Member Name __________________________________________________
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 before aphasia:

Hobbies or interests after aphasia:
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?
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: ____________________________________________________________

Rev 3/2022 Member Name ________________________________________________
MossRehab Aphasia Center (MRAC)
New Member Registration - PPA

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)
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  Description of  Date
Personal Representative  Authority

Project manager: ________________________________

Project name or job number: ________________________________

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

Rev 3/2022 Member Name ___________________________________________________________
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: ________________