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 Aphasia Center (MRAC)
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

Rev 3/2022 Member Name __________________________
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.

Rev 3/2022 Member Name _________________________________
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):

___________________________________________________________________________________________________________

Rev 3/2022 Member Name ________________________________________________________________
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____

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 Aphasia Center (MRAC)
New Member Registration - General

MRAC ACTIVITY SELECTION
All Checks Payable to: MossRehab Aphasia Center

COMPUTER LAB:
$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 smartphone, 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.

Rev 3/2022 Member Name ___________________________________________________
MossRehab Aphasia Center (MRAC)
New Member Registration - General

ACTIVITY REGISTRATION SELECTION
All Checks Payable to: MossRehab Aphasia Center

TALKING BOOK CLUB:  
Cost: $125.00 (Virtual) $150.00 (In Person)

Yes ______ No_______

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.

Rev 3/2022 Member Name ______________________________________________________
MossRehab Aphasia Center (MRAC)
New Member Registration - General

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.

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<th>Person:</th>
<th>Relationship to you:</th>
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**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: _____________________________________________________________________
MossRehab Aphasia Center (MRAC)
New Member Registration - General

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 Personal Representative Description of Authority Date ______________

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: ________________
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.
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:___________________________________________
Due to COVID-19 our building is closed

Potential Benefits
- Stay in touch
- Participate in programs and services

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

Potential Risks
- There is a risk of other people hearing the conversation
- There is a risk of someone accessing your personal documents
- There is a risk of someone interrupting the conversation
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

I agree to participate in online programs and groups

Do you have any questions?

- YES
- NO

Do you understand?

- YES
- NO

Participant Name: _______________________________

Signature: _________________________________

Date: ____________________________

Person Assisting with Completing this Document:

Name: _________________________________

Date: _________________________________