CO0010

Stony Brook
Southampton Hospital
A Location of Stony Brook University Hospital
240 Meeting House Lane Southampton, NY 11968

PATIENT LABEL

General Consent and Agreements for Hospital Ambulatory Services

Patient Consent to the Release of Records for NYS External Appeal

The patient, the patient's designee and the patient's provider have a right to an external appeal of certain adverse determination made by health plans. In the event an external appeal is filed, consent to the release of medical records signed and dated by the patient is necessary. An external appeal agent, assigned by the New York State Department of Financial Services, will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release relevant medical or treatment records related to the external appeal including any HIV-related information, mental health treatment information or alcohol / substance abuse treatment information to the external appeals agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else.

This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding.
I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence or to bring an action against my health plan.

Patient's Health Plan ID # _____

X _____
Signature of Patient (or representative) _____ Time _____ Date _____

**I have read this entire document and I understand it.
I have been given the chance to ask questions and understand
that I may ask additional questions at any time.**

I also understand I may refuse to sign this form and that my health care treatment will not be affected or interrupted and payment will not be affected. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

X _____ _____ _____ _____
Signature of Patient (or representative) Relationship (if other than patient) Time Date

_____ _____
Print Name of Witness Title or Relationship to Patient

X _____ _____ _____
Signature of Witness Time Date

Stony Brook Southampton Hospital

Department of Rehabilitation

Name: _____ **Age:** _____ **DOB**: _____ **Date:** _____

Occupation: _____ **Marital Status: S☐M☐D☐W☐**

Emergency contact info: Name: _____ Number: _____ Relationship:_____

May we speak to significant other regarding your/pt progress? Yes☐No☐

Do you have a health care proxy? Yes☐No☐Name:_____Number:_____

Allergies: List any medication (s) or food that you are allergic to: _____

Are you latex sensitive? Yes☐ No☐

Are you currently pregnant or think you may be pregnant? Yes☐ No☐

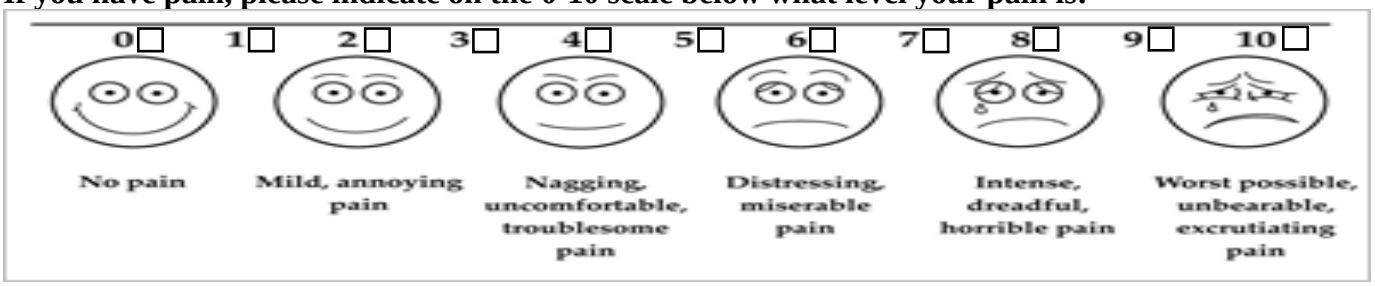
Do you have a pacemaker or defibrillator? Yes☐No☐

Please check (√) any of the following whose care you're under:

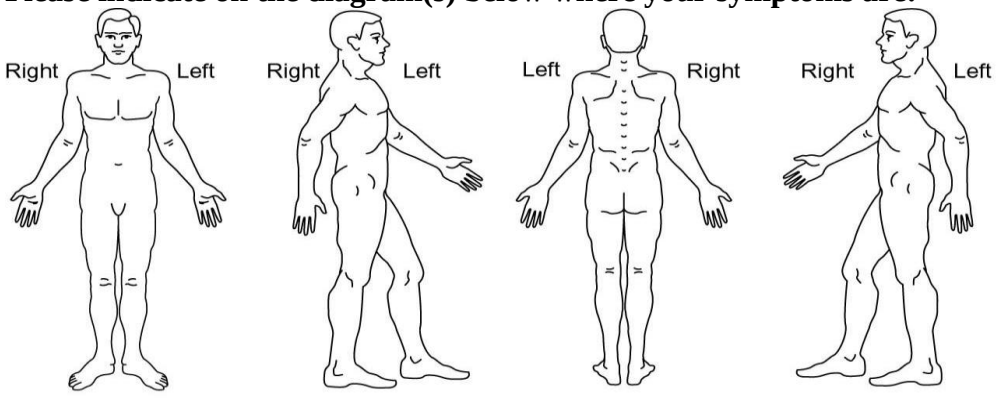
☐ Medical Doctor (MD)
☐ Osteopath Doctor (DO)
☐ Dentist
☐ Physiatrist
☐ Physical Therapist
☐ Chiropractor
☐ Psychologist / Social Worker
☐ Occupational / Speech Therapist
Other: _____

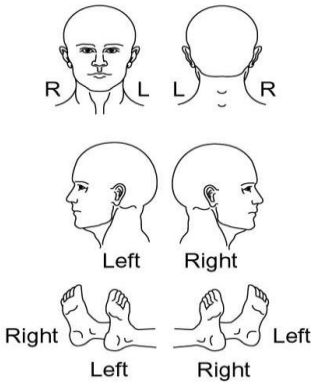
If you have seen any of the above during the past 3 months, please describe for what reason (illness, injury, physical, etc.): _____

If you have pain, please indicate on the 0-10 scale below what level your pain is:



Please indicate on the diagram(s) below where your symptoms are:





What is the reason you are here today? _____

Turn Over For Page 2

Have you ever been diagnosed as having any of the following conditions?

Yes☐No☐ Cancer If yes, what kind? _____
Yes☐No☐ High blood pressure
Yes☐No☐ Heart Disease / Problems ; list; _____
Yes☐No☐ Circulation Problems
Yes☐No☐ Stroke : date; _____
Yes☐No☐ Asthma
Yes☐No☐ Chemical Dependency
Yes☐No☐ Thyroid Problems
Yes☐No☐ Diabetes
Yes☐No☐ Kidney disease
Yes☐No☐ Anemia
Yes☐No☐ Epilepsy
Yes☐No☐ Osteoarthritis ; where; _____
Yes☐No☐ Rheumatoid Arthritis
Yes☐No☐ Other Arthritic Conditions: _____
Yes☐No☐ Multiple Sclerosis
Yes☐No☐ Emphysema / Chronic Bronchitis
Yes☐No☐ Lyme Disease
Yes☐No☐Liver Disease
Yes☐No☐Tuberculosis
Other: _____

Please list any surgeries or other conditions for which you have been hospitalized.

	Reason	Date
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please list any significant injuries that you have been treated for?

	Reason	Date
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please list any prescription medications you are currently taking, dosage and frequency:

1. _____ Dosage:_____ Freq.: _____ 2. _____ Dosage: _____ Freq: _____
3. _____ Dosage:_____ Freq.: _____ 4. _____ Dosage: _____ Freq.: _____
5. _____ Dosage:_____ Freq.: _____ 6. _____ Dosage: _____ Freq.: _____

Which of the following over-the counter medications have you taken in the last two weeks?

Yes ☐ **No**☐Aspirin
Yes ☐ **No**☐Tylenol
Yes ☐ **No**☐Advil / Motrin / Ibuprofen
Yes ☐ **No**☐Laxative
Yes ☐ **No**☐Antihistamine
Yes ☐ **No**☐Decongestants
Yes ☐ **No**☐Antacids
Y**es** ☐ **No**☐Vitamins / Minerals/ Supplements
Other: _____

Have you recently noted:

Yes ☐ **No** ☐ Weight loss / gain
Yes ☐ **No** ☐ Nausea
Yes ☐ **No** ☐ Fatigue
Yes ☐ **No** ☐ Weakness : where? _____
Yes ☐ **No** ☐ Fever / Chills / Sweats
Yes ☐ **No** ☐ Numbness / Tingling: where? _____

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction, which include but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic conditions.

I understand that to evaluate/treat my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination/treatment is performed by observing and/or palpating the perineal region, including vaginal and/or rectum. This evaluation and/or treatment will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation/treatment may include vaginal or rectal sensors for muscle biofeedback.

Signature:_____ Date:_____

PFDI- 20 Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the **last 3 months**.

The PFDI-20 has 20 items and 3 scales of your symptoms.
All items use the following format with a response scale from 0 to 4.

Symptoms Present = YES, scale of bother: 1 = not at all
2 = somewhat
3 = moderately
4 = quite a bit

Symptoms Not Present = NO 0 = not present

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you …	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0 ☐	1☐2☐3☐4☐
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0 ☐	1☐2☐3☐4☐

Colorectal-Anal Distress Inventory 8 (CRAD-8):

Do you …	No	Yes
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary Distress Inventory 6 (UDI-6):

Do you …	No	Yes
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0 ☐	1☐2☐3☐4☐
18. Usually experience small amounts of urine leakage (that is, drops)?	0 ☐	1☐2☐3☐4☐
19. Usually experience difficulty emptying your bladder?	0 ☐	1☐2☐3☐4☐
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0 ☐	1☐2☐3☐4☐

Scoring the PFDI-20:

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFSI-20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).

PFIQ – 7 Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question place an **X** in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in all 3 columns for each question.

How do symptoms or conditions relating to the following → → → Usually affect your …↓	***Bladder or urine***	***Bowel or rectum***	***Vagina or pelvis***
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit
5. Participating in social activities outside your home?	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit
6. Emotional health (nervousness, depression, etc.)?	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit
7. Feeling frustrated?	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit

Stony Brook Southampton Hospital

Welcome to the Southampton Hospital Wellness Department

Southampton Hospital would like to thank you for selecting us as your provider of wellness services. We will do everything possible to assure that your treatment is of the highest quality. You will always be treated professionally and with respect while you are in our care. We take pride in the quality of care that we provide. We have established some guidelines in order to ensure the highest of quality care for all of our patients:

- Contact us if you anticipate arriving more than 15 minutes late for your appointment to determine if we will still be able to meet your needs. **Please call us 24 hours in advance if you need to cancel and/or reschedule an appointment.**
- If you are unable to keep an appointment and do not call to cancel 24 hours in advance, we will not be able to use that time to schedule another patient in your place. **In that case, you will be charged the full fee for your service. It will be your responsibility to pay. This fee must be paid before your next scheduled appointment.** The intention of this policy is to enable us to utilize all our treatment slots to meet the increasing need for our therapy patients.
- For PHYSICAL THERAPY ONLY: Most insurances, including Medicare, determine the number of visits that they will cover you for therapy. You are responsible for any co-pays or deductibles required by your insurance plan. If you have any questions about your coverage, please ask the front desk staff.

We appreciate your cooperation and will do our best to accommodate your needs.

Release of Medical Records

I authorize the release of any medical information necessary to my physician and my insurance provider to process claims or authorize visits. This information may include history and date of current illness, medical and surgical history, diagnostic results, as well as information regarding my progress during rehabilitation.

Signature:_____ Date:_____

Acknowledgement of Receipt of Privacy Notice

I, _____, acknowledge that I have been provided with a copy of Stony Brook Organized Health Care Arrangement-Joint Notice of Privacy Practices.

Patient Signature:_____ Date:_____

Signature of Registrar:_____ Date:_____

Advanced Directives

Do you have and Advanced Directive (Living Will, DNR, Health Care Proxy)? Yes_____ No_____

If **YES**, please bring a copy to keep in your chart. If **NO**, and you would like to know more and/or develop an Advanced Directive, please speak with our receptionist, so that we may provide you this information.

Signature:_____ Date:_____