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

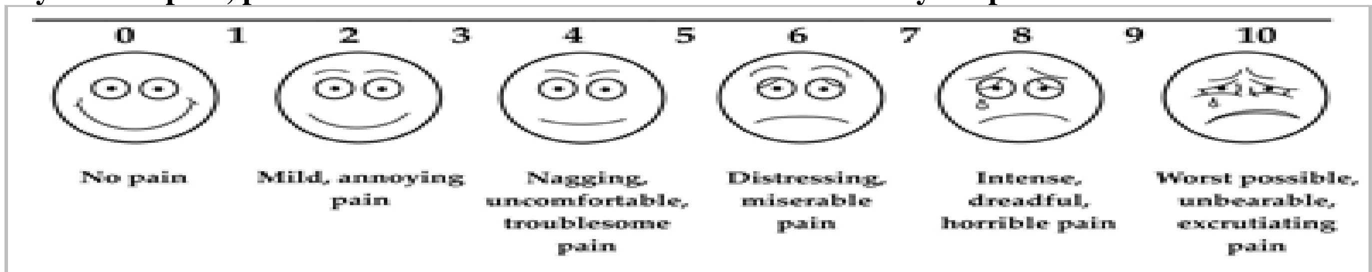
Do you have a pacemaker or defibrillator? Yes No

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

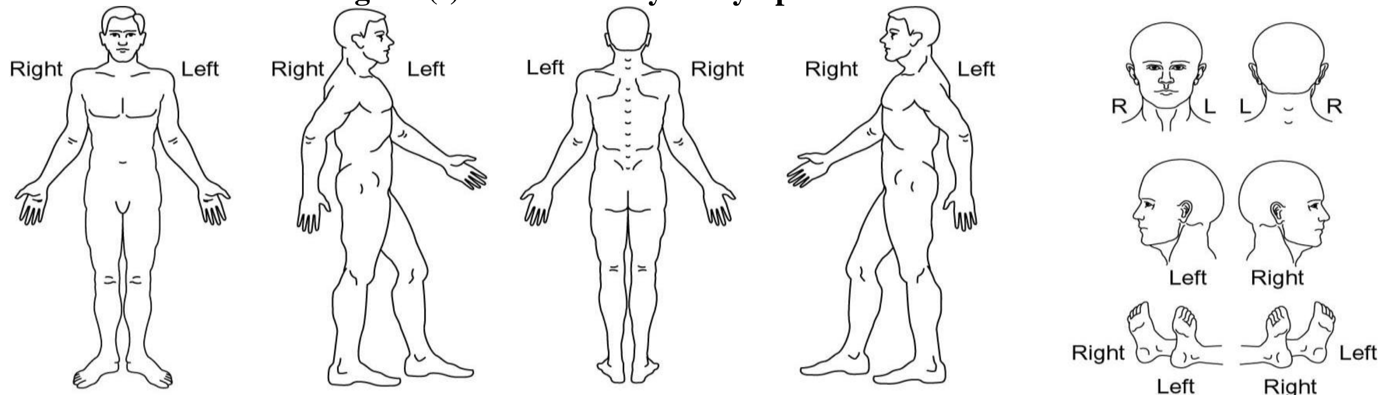
____ Medical Doctor (MD) ____ Physiatrist ____ Psychologist / Social Worker
____ Osteopath Doctor (DO) ____ Physical Therapist ____ Occupational / Speech Therapist
____ Dentist ____ Chiropractor Other: ___________________________________

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:

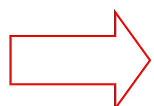


Please indicate on the diagram(s) below where your symptoms are:



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
Yes **No** Vitamins / Minerals/ Supplements

Other: ____

Have you recently noted:

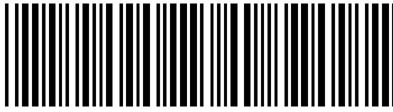
Yes **No** Weight loss / gain
Yes **No** Nausea
Yes **No** Fatigue

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:______________________


AD2C679

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow members of the Stony Brook Organized Health Care Arrangement (listed on Exhibit A) (referred to as the "SBOHCA" or "Provider Organization") to obtain access to my medical records through the Statewide Health Information Network of New York (SHIN-NY) via Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit Health Information Exchange (HIE) organization, certified by the NYSDOH, that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2 and New York State Law. To learn more visit Healthix's website at www.healthix.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the SBOHCA to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).

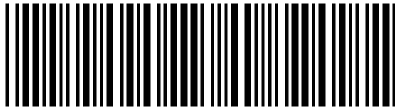
☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for SBOHCA to access my electronic health information through Healthix.

☐ **3. I DENY CONSENT** for SBOHCA to access my electronic health information through Healthix for any purpose, ***even** in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative X	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)


AD2C679

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Medication and Dosages
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Diagnostic information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test
   - Trauma history summary

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by checking Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, contact the Provider Organization at: **hipaa@stonybrookmedicine.edu** or Healthix at **compliance@healthix.org**; or call the NYS Department of Health at **518-474-4987**; or follow the complaint process of the federal Office for Civil Rights at the following link: **http://www.hhs.gov/ocr/privacy/hipaa/complaints/**.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice, until such time as Healthix ceases operation or until 50 years after your death, whichever occurs first. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.

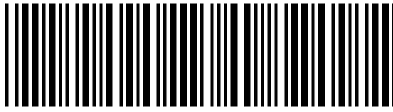
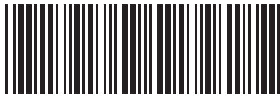

AD2C679

EXHIBIT A
MEMBERS OF THE SBOHCA

The following entities are members of the SBOHCA

1. Stony Brook University Hospital, including:
    - Stony Brook Children's Hospital
    - Stony Brook Southampton Hospital
    - Stony Brook Eastern Long Island Hospital
2. University Faculty Practice Corporations. To review the list of all participating providers please visit the following webpage https://www.stonybrookmedicine.edu/locations
3. SB Community Medical, PC. To review the list of all participating providers please visit the following webpage https://www.stonybrookmedicine.edu/community-medical/practices
4. Meeting House Lane Medical Practice, PC


CO0010

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

General Consent and Agreements for Hospital Ambulatory Services

By signing this document:

1. **General Consent for Treatment:** I consent for Stony Brook University Hospital (Stony Brook University Hospital including all locations) to perform routine diagnostic and treatment procedures including radiology services, blood tests, IVs (intravenous fluids) and medications. I understand that for Outpatient Visits, Ambulatory Visits, Testing Services and Physician Visits this general consent and agreement will be effective for one year from the date of my signature unless withdrawn. I further understand any Inpatient Admissions, Ambulatory Surgery Procedures, Emergency Department Visits and Observation Stays will require a new additional general consent and agreement to be completed and signed.

2. **Telehealth Services:** I understand that I may elect to get Telehealth Services.

   Telehealth includes both telemedicine and remote patient monitoring. Telemedicine is the use of two-way, real time interactive audio video communication between patient and physician or other licensed clinical providers which include assessment, diagnosis and treatment.

   Images and conversations from the Telehealth video conferences may be recorded and may become part of the electronic medical record.

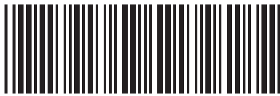
   My doctor will document Telehealth notes in my medical chart in the same manner as in a face to face session. I may withhold or withdraw my consent to Telehealth services at any time, and it will not affect my future care.

3. **Disposal of Tissues and Specimens:** I understand that all tissues and specimens removed from me during my care and treatment become the property of Stony Brook University Hospital. I also authorize Stony Brook University Hospital to dispose of such tissues and specimens as appropriate when required.

4. **Responsibility for Patient Care:** I understand that my attending physician is responsible for my care and that he /she may assign other physicians, practitioners and hospital staff members as deemed appropriate to provide care to me. I also understand that since Stony Brook University Hospital is a teaching facility, medical, nursing, social work and other students may observe or assist in my care under the direction of my physician and other staff members.

5. **Photographs / Video / Voice Recordings:** I understand that photographs, video and / or voice recordings may be taken of me and used for medical purpose such as documenting or planning my care as well as for teaching or for publication in a scientific journal. Prior to any publication or disclosure of the photographs, video and / or voice recordings, other than as part of a Telehealth video conference, we will obtain your written authorization, unless the images / recordings do not identify you or have been changed so that they no longer identify you. I understand that the photographs, videos and / or voice recordings taken to document my care are part of my medical record and those taken for other purposes are not part of my medical records.

6. **Information Guides:** I acknowledge that, in accordance with the New York State Department of Health guidelines, I have received the booklet titled *What You Need To Know as a Patient.*



CO0010

Stony Brook
Southampton Hospital
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240 Meeting House Lane Southampton, NY 11968

PATIENT LABEL

General Consent and Agreements for Hospital Ambulatory Services

Privacy Acknowledgement

<u>Privacy Acknowledgement</u>: I acknowledge that I have been provided a copy of the Stony Brook Organized Health Care Arrangement-Joint Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by the facilities listed at the beginning of the privacy notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request additional information explaining special privacy protection that applies in other areas such as HIV related information, mental health and genetic counseling. I have received the Joint Notice of Privacy Practices as of this date, or at a previous visit, not earlier than April 14, 2003.

<u>Release of Information</u>: I consent to the release of all or part of my health record, including my social security number to insurance carriers, government agencies, and other third-party payors as needed in order for Stony Brook University Hospital to obtain reimbursement for my care. I also understand that my social security number may be provided to the New York State Department of Health in accordance with incidence reporting and other New York State hospital regulatory requirements and to manufacturers of medical devices and the Federal Food and Drug Administration for medical device tracking purposes. I consent to the use and disclosure of my protected health information as necessary to treat my condition, obtain payment for treatment and conduct health care operations.

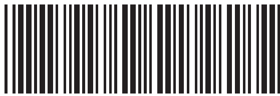
I understand the above information is protected by Federal Regulation 42CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I need not consent to the Release of Information in order to obtain treatment services, I choose to do so willingly and voluntarily for the purposes provided above. This consent shall expire twelve (12) months or upon the date, event, or condition listed below.

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it.

Release of Information to Primary Care Practitioner & Uniform Assignment

<u>Release of Information to Primary Care Practitioner</u>: I authorize Stony Brook University Hospital and its Emergency Department staff to disclose the health care related information for this Emergency Department encounter to my Primary Care Practitioner (PCP) for the purpose of continuity of my health care. I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection.

<u>Uniform Assignment</u>: I transfer, assign and set over to Stony Brook University Hospital / University Faculty Practice Corporations / 24-7 Emergency Care, PC, sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs and treatment rendered to myself or my dependent.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General Consent and Agreements for Hospital Ambulatory Services

Financial Agreement / Guarantee of Payment: I, the undersigned patient or responsible party, agree to be fully responsible for payment to Stony Brook University Hospital / University Faculty Practice Corporations / 24-7 Emergency Care, PC for the care and treatment of the patient whose name appears on this form.

I understand that this includes cost-sharing payments to the provider (including any co-payments and deductibles) for care and treatment as required by the patient's health insurance contract and benefits.

I understand that the patient is responsible for ensuring that authorizations and approvals are obtained as required by their insurance company. If prior approval is not obtained when required or authorization has been denied, I am fully responsible for all charges that the insurance company does not pay, as may be specified under the provisions of my insurance contract and the extent permitted by law.

I understand that I am responsible to provide accurate information to the provider regarding: contact, demographic, health insurance and other pertinent information required for hospital / professional billing and that I must promptly notify the provider of any changes in this information. I agree to provide any other information reasonably requested by the provider in order to bill for the care and treatment provided.

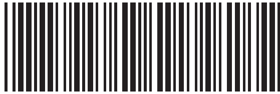
Hospital Billing / Financial Services: Stony Brook University Hospital: 631-444-4151
Stony Brook Southampton Hospital (SBSH): 631-723-2160
Stony Brook Eastern Long Island Hospital: 631-477-5555

Additional Contact Numbers: Stony Brook CPMP (Physician & Hospitalist) Services: 631-444-4800
SBSH Emergency Room Physician Billing (24-7 Emergency Care, PC): 1-855-691-9890
Stony Brook Southampton Hospitalist Billing: 631-726-3172
Meeting House Lane Medical Practice (Physician): 631-283-1126

You may contact your Physician or Hospitalist Practice with questions regarding your physician / hospitalist bill.

MEDICARE ASSIGNMENT OF BENEFITS FOR MEDICARE PATIENTS

Medicare Assignment of Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf directly to the physician or organization providing medical care. I assign, transfer and set over all benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment.


CO0010

Stony Brook
Southampton Hospital
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240 Meeting House Lane Southampton, NY 11968

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

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

Documentation of Interpreter or Special Assistance

An interpreter or special assistance was used to obtain consent from this patient as follows:

- ☐ Foreign Language *(specify)* ______________________________
- ☐ Sign Language
- ☐ Visually Impaired
- ☐ Other *(specify)* ______________________________

Interpretation or special assistance provided by ______________________________
(Fill in name of interpreter and title or relationship to patient)

X______________________ ______________________ ______________________
Signature of Witness Time Date

Verbal Consent

When verbal consent is given, telephonically or in person, the person giving consent/agreement/acknowledgment or refusal clearly states their name, date of birth and relationship to the patient. This is documented clearly on the general consent and agreements form.

I______________________, verify my name as stated. My address is______________________,______________________.
(Name) *(Street Address)* *(City, Village, Hamlet)*

My phone number is______________________, my date of birth is______________________, and my relationship to

the patient is______________________.

Further, all verbal consent, telephonic and in person, is witnessed by two employees working at any of the campus locations of Stony Brook University Hospital.

______________________ X______________________ ______________ ______________
Print Name of Witness 1 Signature of Witness 1 Time Date

______________________ X______________________ ______________ ______________
Print Name of Witness 2 Signature of Witness 2 Time 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

All of the items use the following response scale:
0 = not at all; 1 = somewhat, 2 = moderately, 3 = quite a bit

Scales:
Urinary Impact Questionnaire (UIQ-7); 7 items under column heading “Bladder or urine.”
Colorectal-Anal Impact Questionnaire (CRAIQ-7): 7 items under column heading “Bowel or rectum.”
Pelvic Organ Prolapse Impact Questionnaire (POPIQ-7): 7 items under column heading “Pelvis or vagina.”

<u>Scale scores</u>: Obtain the mean value for all of the answered items within the corresponding scale (possible value 0 to 3) and then multiply by 100/3) to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.
Total score of each section ________ divided by 7 ______ X 33.3 = _________

<u>PFIQ-7 Summary Score</u>: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).

Barber, M., Walters, M., et al. (2005). "Short forms of two condition-specific quality of life questionnaires for women with pelvic floor disorders (PFDI-20 and PFIQ -7)." American Journal of Obstetrics and Gynecology 193: 103-113.

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:________________________