

Welcome to SERC

Spine and Extremity Rehabilitation Center

We are pleased that you and/or your doctor have chosen SERC to provide your physical therapy services. As private owners and providers of all professional services at SERC, we welcome you.

Rehabilitation is hard work and can be uncomfortable. Therapists and patients must have mutual respect and effective communication to maximize the benefit of treatment. Please understand, however, that 'Hurt' is different than 'Harm.' We will be working with you to address your pain and help you attain your goals.

In order to achieve these goals, we expect you to **commit** to physical therapy and the plan the doctor and physical therapist have outlined for you. This means you will receive your physical therapy treatments as prescribed, usually 2-3x/week, that you must be an active participant in your treatment, comply with the home exercise program outlined for you, and continue independently when the therapist and you decide you are ready and able. When you arrive here as a patient, SERC is committed to you. With this level of commitment, as a team, we will be better able to help you reach your goals.

We will make efforts to schedule you at convenient times. When you schedule for this time, it is reserved for **your** treatment. We ask that you give us 24 hours **advance** notice if you need to reschedule so we can offer this time to someone who may need your time. If two or more visits are missed without 24 hours notice, you will be billed \$20.

Patient outcomes are important to us at SERC. We want to track how our patients improve, so we can report these improvements quantitatively back to your physician(s), case manager and/or insurance company if necessary

We realize that understanding your condition is a vital part of this process; that's why we provide a resource through our website that we know you will find helpful. Log onto our website www.sercrehab.com, then click on "medical library" and then the appropriate body region and related article.

We believe communication with your doctor is vitally important, and we will provide them with regular written updates (reports) on your progress.

Again, thank you for choosing SERC.

Respectfully,

Matt and Lori

I have read and understand the above and commit to what my doctor and physical therapist have outlined for me.

Name (please use black ink)

Date



SERC
 406 Grace Ave.
 Woodland Park, CO 80863
 Phone: (719) 687-3767
 Fax: (719) 687-2525
 Email: staff@sercrehab.com
 www.sercrehab.com

Patient Information Questionnaire

(Please use black ink)

Today's Date: _____

Name:	Home Phone:
Mailing Address:	Work Phone:
City, ST Zip:	Cell Phone:
Who referred you?	Date of Birth:
Social Security #:	Current Age:
Emergency Contact:	Emergency Contact Phone No.:
Primary Physician:	When is your next Dr.'s appt.?

1. Work Information: (please fill out as applicable)

Employment Status: Full Time Part Time Not Employed Retired

Employer: _____ Phone: _____

Full duty? No Yes Restricted duty? No Yes # of Hours per wk. _____

What are your job duties/responsibilities? _____

How many total work hours/days have you missed as a result of this problem? _____ Last date worked? _____

2. Tell Us About Your Condition:

When did you first notice the pain or have problems due to this problem/injury? _____

How did your problem/injury occur? _____

Are your symptoms: Constant? Intermittent?

Getting: Better? Worse? Same?

What is your main problem related to this injury? _____

Please use this scale to answer the following 4 questions (0=No Pain, 10=Worst pain imaginable):

Worst pain with activity: _____ Normal pain at rest: _____

Today's pain: _____ Night pain: _____

Please describe the pain: Sharp Dull Burning Electrical
 Cramping Boring Throbbing

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you had surgery for this injury? No Yes
 If yes, when? _____ What kind? _____

Have you received any injections for this injury? No Yes
 If yes, when? _____ Did it help? No Yes

Please list any diagnostic tests received for this problem/injury: _____

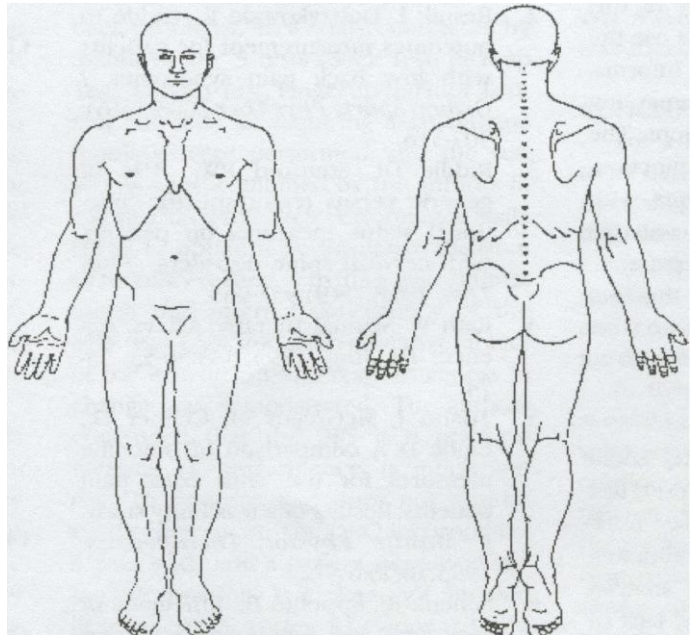
Who else have you seen for your problem/injury? _____

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

Key

/// Sharp/ Stabbing	XXX Burning	OOO Pins/ Needles	=== Numbness	ZZZ Deep Ache	TTT Dull/ Boring
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3. Medical History:

Have you or any immediate family member ever been diagnosed as having any of the following conditions:

No	Me	Family Member		No	Me	Family Member	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (What kind): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependency (i.e., alcoholism)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina or chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis/Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other arthritic conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/Stomach problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Please describe) _____				

Is there a chance you might be pregnant? No Yes Are you on a special diet? No Yes (specify) _____

Do you have any allergies (e.g. latex, adhesives, cortisone)? No Yes _____

Please list prior surgeries/other pertinent musculoskeletal history: _____

Please list current medications (prescription/over the counter): _____

Have you had any illness/infections in the last three weeks? No Yes _____

Have you noticed any lumps or thickening of skin or muscle anywhere on your body? No Yes _____

Do you have any sores that have not healed or any changes in size, shape or color of a wart or mole? No Yes _____

Do you have a pacemaker, transplanted organ, or metal implants? No Yes _____

Have you recently noted:

- | | | | | | |
|-----------------------------|------------------------------|------------------------------|-----------------------------|------------------------------|-------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Unexplained weight loss/gain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Fever/chills/sweats |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Nausea/vomiting | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Numbness or tingling |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Fatigue | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Nocturnal or unrelenting pain |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Weakness | | | |

How much caffeinated coffee or caffeine-containing beverages do you drink per day? _____

Do you smoke? No Yes How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

How would you describe your general health: Poor Fair Good Excellent

Are you currently exercising? No Yes Please describe: _____

Please describe any problems with exercise: _____

Date of last physical exam: _____

What do you hope to accomplish with physical therapy? _____

Please include any additional information you feel would help us provide your care (i.e., what you think would help, any apprehensions about treatment; spiritual or cultural needs, etc.): _____

To the best of my knowledge, the above information is complete & factual.

 Patient Signature

 Date

Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem.

Activity #1: _____

Scoring Scheme

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform activity at pre-injury level	

Activity #2: _____

Scoring Scheme

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform activity at pre-injury level	

Activity #3: _____

Scoring Scheme

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform activity at pre-injury level	

Payment Policy

Initial:

- _____ **PATIENTS WITH INSURANCE:** You will be responsible for paying your annual deductible, copayment, or co-insurance and any charges for **NON-COVERED SERVICES** as indicated on the explanation of benefits (EOB) and per your insurance plan.
- _____ **ACCOUNT STATEMENTS:** Statements are mailed every month. Any unpaid patient balance after 60 days will be sent to collections. 30% will be added to the balance for collection fees.

Consent to Treat and Authorization to Release Information

Initial:

- _____ I consent to **evaluation and treatment** by SERC of Woodland Park, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.
- _____ I authorize the **release of information** acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my physician(s), insurance company and employer (if work-related injury).
- _____ I authorize **phone messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.
- _____ A copy of this facility's **Statement of Privacy Notice** has been provided to me.
- _____ I have read and understand my rights and responsibilities as a patient.

Patient's Signature

Date

Signature of Responsible Party
(if different than patient)

Relationship

SERC Spine and Extremity Rehabilitation Center Statement of Privacy Notice

Effective April 4, 2005

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

Please review the information carefully.

- Your protected health information may be released to your insurance provider for the purpose of SERC Spine and Extremity Rehabilitation Center (SERC) receiving payment for providing you with needed physical therapy services. SERC might share your health information with your physician for payment activities related to the care you received.
- Your protected health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your protected health information may be released to other healthcare providers in the event you need emergency care.
- Information regarding your appointment time, presence at our facility, or other general details of your scheduled appointments may be provided over the phone to caller's who request so by providing your name.
- Your protected health information may be released only after receiving written authorization from you with the exception of those listed above or for treatment, payment, or healthcare operations. You may revoke your permission to release protected health information at any time. It must be in writing with effective date and be specific to the health information being protected. SERC is not required to agree to your request.
- You may be contacted by SERC by phone or mail (or leave a message on an automated answering device) to remind you of appointments, verify insurance/demographic information, etc. You have the right to request a more confidential way of providing your protected health information or alternative communication method at the time you are seen at SERC will honor all reasonable requests.
- You have the right to restrict the use of your protected health information. However, SERC may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation.
- You have the right to review and photocopy any/all portions of your health information. SERC has the right to assess a fee for the photocopying of the health information.
- You have the right to request an amendment to your health information. It must be in writing and explain why the information should be amended. SERC can deny the amendment and if so, a written explanation will be provided.
- You have the right to possess a copy of this Statement of Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- SERC is required by law to protect the privacy of its patients. It will keep protected any and all patient health information and will provide patients with a list of practices that protect health information upon written request.
- SERC will abide by the terms of this notice. SERC reserves the right to make changes to this notice and will continue to maintain the confidentiality of all health information. Changes to this notice will be redistributed at your next visit to SERC
- You have the right to complain to SERC if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your written complaint to:
SERC Spine and Extremity Rehabilitation Center
ATTN: Patient Information Privacy Officer
700 W Hwy 24 Suite D
Woodland Park, CO 80863
- All complaints will be investigated. No personal issue will be raised for filing a complaint with SERC
- You may also file a complaint to:
Region IV, Office of Civil Rights
US Dept. of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street SW
Atlanta GA 30303-8909
- If you would like more information regarding this Privacy Notice, please contact our Privacy Officer at (719) 687-3767.