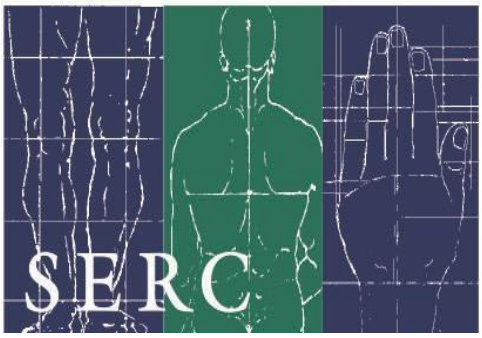


Spine and Extremity Rehabilitation Center

406 E Grace Ave Woodland Park, CO 80863
[P] 719.687.3767 [F]719.687.2525
www.sercrehab.com

WELCOME TO SERC 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 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 1-2x/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 from you, as a team, we will be better able to help you reach your goals.**

Again, thank you for choosing SERC!

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

_____	_____	_____
Printed Name	Signature	Date

Spine and Extremity Rehabilitation Center

CANCELLATION POLICY

Please give us 24 hours advance notice if you need to cancel / reschedule. This enables us to offer this time to another patient who needs our care. Cancellations may be left via voicemail (voicemails are accurately time-stamped).

There is a $50.00 Cancellation Fee per missed visit, if two or more visits are missed without 24 hours notice. Cancellation Fees are not billable to insurance and must be paid by the patient. Exceptions are made due to weather, illness or unavoidable emergencies. If you "no show" or late cancel for two (2) or more scheduled appointments, we reserve the right to schedule your future appointments on a stand-by basis only, or dismiss you as a patient from our clinic.

We make efforts to schedule your appointments at convenient times. As a courtesy, you will receive automated voice or text appointment reminders (unless you wish to opt out of this service). However, ultimately you are responsible for knowing and keeping your appointments. Let us know if you did not receive your notice.

Signing below, states you have read and are aware of the Cancellation Policy and Fee.

_____ _____ _____

Printed Name Signature Date

FINANCIAL POLICY

Please be aware of your medical insurance policy/coverage.

As a courtesy, we verify insurance benefits on your behalf. However, we are often given inaccurate information by insurance companies, concerning copays / coinsurance, deductible & out of pocket accumulations, visit limitations, and/or network information. Any discrepancies must be resolved between you and your insurance company. Your insurance is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan as long as you provide us with the correct information, including any changes in your coverage.

Cash/Self Pay Fees, Copays and/or Coinsurance are due at time of service. You will receive a statement only if a balance is due on your account. If a credit/refund is owed to you, a check will be issued to you after claims have been fully processed. Please call the phone number on your SERC Billing Statement (our billing dept.) for balance or credit questions. Please note that most insurance companies do not cover 100% of therapy visits, and there may be a portion or possibly all of your visits for which you will be responsible. In the event your benefits do not cover our physical therapy services and fees, please remember that you are responsible for the total cost of your treatment.

A service fee of $5.00 will be added to your balance after the first and the second statement if payment is not received. After the third statement, if no payment is made, your account may be sent to collections. Be sure your address is correct and current on your account for your mailed statements/refunds.

Signing below, states that you have read and are aware of the Financial Policy.

_____ _____ _____

Printed Name Signature Date

_____ _____

Office Witness Date

406 E Grace Ave Woodland Park, CO 80863 [P] 719.687.3767 [F]719.687.2525 www.sercrehab.com

PATIENT INFORMATION

Name:	Today's Date:
Address:	Home Phone:
City, ST Zip:	Cell Phone:
Who referred you?	Email address:
Social Security #:	Date of Birth:
Emergency Contact Name:	Current Age:
Emergency Contact Phone #:	Primary Physician:

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION

Please Initial ALL in acknowledgement:

_____ 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 insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer.

_____ I authorize **phone/text messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided. I understand I will receive automated text or voice appointment reminders.

_____ A copy of this facility's **Statement of Privacy Notice** has been provided to me. (see the last page in this packet)

_____ I have read and understand my rights and responsibilities as a patient.

PAYMENT POLICY

Please Initial ALL in acknowledgement:

_____ **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 your explanation of benefits (EOB) and per your insurance plan.

_____ **INSURANCE PAYMENT AUTHORIZATION**: I authorize insurance payments to be paid directly to SERC for services and treatment.

_____ **ACCOUNT STATEMENTS**: Statements are mailed at the beginning of each month. Fees will be assessed after the 2nd and 3rd statement. If three statements are mailed to the patient indicating a patient balance is due, and no payment has been received or no contact is made by the patient to arrange a payment schedule, the account will be turned over to our collection agency. Credits or refunds owed to you for overpayment will be paid when insurance and billing has completely processed the claims.

The information I have provided in the Patient Information, Health History Questionnaire and Current Health/Condition Information is complete, true, and factual, to the best of my ability.

_____ _____

Patient's Signature Date

_____ _____

Signature of Responsible Party Relationship

CURRENT HEALTH

HOW WOULD YOU DESCRIBE YOUR CURRENT HEALTH

Poor Fair Good Excellent

Have you recently noted: (circle any that apply)

Unexplained weight loss or gain Nausea / vomiting Dizziness / Blurred Vision Unexplained Cough / Chest Pain

Fever / chills / sweats Numbness / tingling Nocturnal Unrelenting Pain Blood Pressure Changes

Numbness in Groin Area

Illness / Infections in last 3 weeks?

Any Lumps or thickening of skin or muscle (anywhere on your body)? _____

Unhealed / Unusual sores? _____ Changes in shape / color / size of a wart or mole? _____

Do you have a Pacemaker? _____ Transplanted Organ? _____ Metal Implants? _____

Is there any possibility you are pregnant? _____ Are you on a special diet? _____

Date of last Physical Exam: _____ Height _____ Weight _____

CURRENT CONDITION

TELL US ABOUT YOUR CURRENT 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/issue?

_____

What makes your symptoms worse?

_____

What makes your symptoms better?

_____

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

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

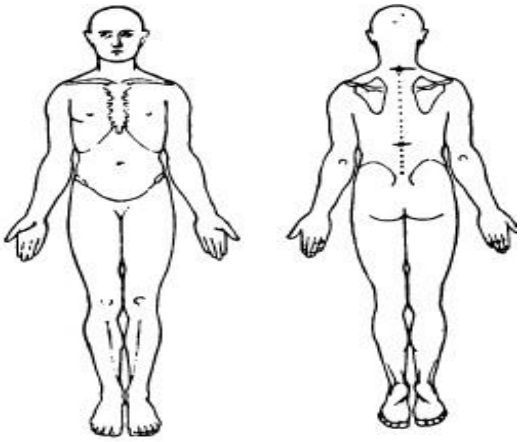
Please list any diagnostic tests received for this problem/injury:

Who else have you seen for this problem / injury?

_____

What do you hope to accomplish with your Physical Therapy? _____

Tell us any additional information you feel would help us provide your care (apprehensions, spiritual or cultural needs etc.)



INSTRUCTIONS

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

HEALTH HISTORY QUESTIONNAIRE

CURRENT WORK / EMPLOYMENT INFORMATION

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? _____

HEALTH AND PERSONAL HABITS

EXERCISE:

- Sedentary (no exercise) or Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
- Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min)
- Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 min)

Describe any problems or issues you have with exercise:

TOBACCO USE:

- Do not use or Year Quit _____
- Cigarettes #packs a Day _____ # of years of use _____

PERSONAL HEALTH HISTORY

HAVE YOU OR AN IMMEDIATE FAMILY MEMBER EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING: (CIRCLE ALL THAT APPLY)

Cancer (what kind) _____ Chemical Dependency Tuberculosis Angina/Chest Pain

Heart Problems Multiple Sclerosis Stroke High Blood Pressure Rheumatoid Arthritis

Kidney Disease Thyroid Problems Epilepsy Anemia Asthma / Emphysema/Bronchitis

Depression Diabetes Hepatitis / Jaundice Cirrhosis / Liver Disease Ulcers / Stomach Problems

Surgeries / Hospitalizations pertinent to muskuloskeletal history

Year Surgery/Hospitalization Reason

Allergies (latex, adhesives, etc.)

Current Medications

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
  406 E Grace Avenue
  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.