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 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 want to track how our patients improve, so we can report these

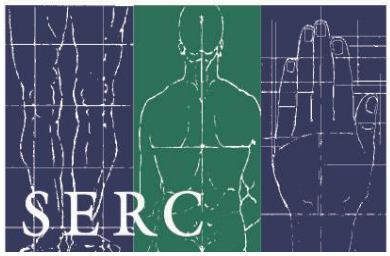
improvements quantitatively back to your physician(s), case manager and/or insurance company if necessary. We believe communication with your doctor is vitally important, and we will provide them with regular written updates (reports) on your progress.

Again, thank you for choosing SERC!

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

_____ _____ _____

Printed Name Signature Date



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CANCELLATION POLICY

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 charged a $20.00 Cancellation Fee.

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

_____ _____ _____

Printed Name Signature Date

FINANCIAL POLICY

As a courtesy we verify insurance benefits on our patients' behalf so that you are aware of your out-of-pocket cost up front. Occasionally we are given inaccurate information. Because the contract is between you and your insurance company any discrepancies must be resolved by the insured and the carrier. Please contact your insurance company with discrepancies.

In the event that a balance remains due on your account you will be sent a monthly statement. A service fee of $5.00 will be added to your balance after the first statement if payment is not received. After the second statement, if no payment is made, it is up to SERC Rehabilitation Center to determine if the account will be sent to collections. Please call the number on your SERC Billing Statement for questions on your balance. Signing below, states that you have read this policy and are aware of the Financial Policies.

_____ _____ _____

Printed Name Signature Date

_____

_____ _____

Office Witness Date

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

Patient Information Questionnaire

Today's Date: _____

Name:	Home Phone:
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:

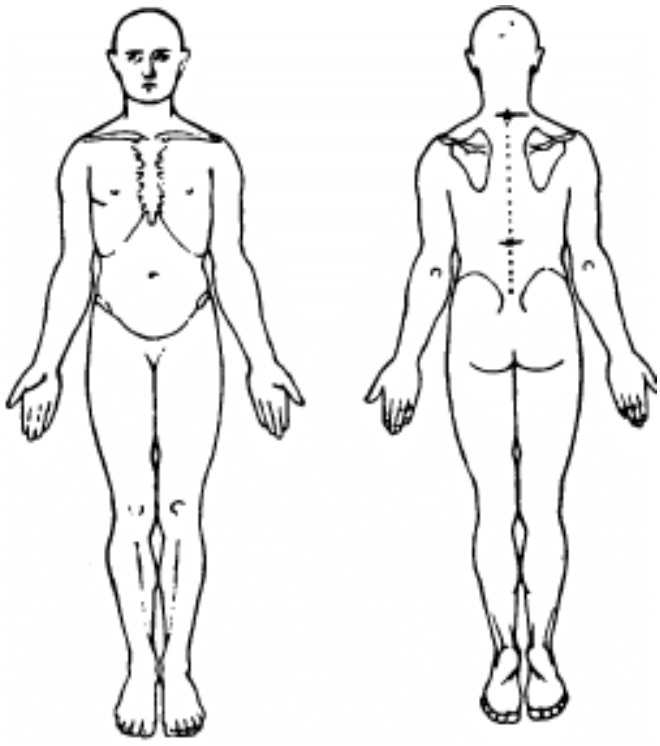
When did you first notice the pain or have problems due to this problem/injury? _____
How did your problem/injury occur? _____
_____
Are your symptoms: ☐ Constant? ☐ Intermittent?
Getting: ☐ Better? ☐ Worse? ☐ Same?
What is your main problem related to this injury?
_____
Please use this scale to answer 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



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	
☐	☐	☐	Cancer (What kind): _____	☐	☐	☐	Depression
☐	☐	☐	Heart problems	☐	☐	☐	Hepatitis/Jaundice
☐	☐	☐	High blood pressure	☐	☐	☐	Tuberculosis
☐	☐	☐	Circulation problems	☐	☐	☐	Stroke
☐	☐	☐	Asthma	☐	☐	☐	Kidney disease
☐	☐	☐	Emphysema/Bronchitis	☐	☐	☐	Anemia
☐	☐	☐	Chemical dependency (i.e., alcoholism)	☐	☐	☐	Epilepsy
☐	☐	☐	Thyroid problems	☐	☐	☐	Angina or chest pain
☐	☐	☐	Diabetes	☐	☐	☐	Shortness of breath
☐	☐	☐	Multiple sclerosis	☐	☐	☐	Urinary tract infection
☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	Cirrhosis/Liver disease
☐	☐	☐	Other arthritic conditions	☐	☐	☐	Ulcers/Stomach problems
☐	☐	☐	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:

☐ No	☐ Yes	Unexplained weight loss/gain	☐ No	☐ Yes	Fever/chills/sweats
☐ No	☐ Yes	Nausea/vomiting	☐ No	☐ Yes	Numbness or tingling
☐ No	☐ Yes	Fatigue	☐ No	☐ Yes	Nocturnal or unrelenting pain
☐ No	☐ 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. For the first set of numbers under each activity, 0 means that you can perform stated activity at your pre-problem level and 10 means that you are unable to perform stated activity. Circle a number that best describes your current level between 0 and 10. For the second set of numbers under each activity, 0 means no pain and 10 means worst pain while currently performing that stated activity.

Activity #1: _____

Scoring Scheme

0 1 2 3 4 5 6 7 8 9 10

Able to perform activity at same level as before your problem — Unable to perform activity

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain

Activity #2: _____

Scoring Scheme

0 1 2 3 4 5 6 7 8 9 10

Able to perform activity at same level as before your problem — Unable to perform activity

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain

Activity #3: _____

Scoring Scheme

0 1 2 3 4 5 6 7 8 9 10

Able to perform activity at same level as before your problem — Unable to perform activity

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain

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 at the beginning of each month. If two 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.

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

_____ 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

_____

Date

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.