Welcome to
SERC Physical & Hand Therapy

We are pleased that you and/or your doctor have chosen SERC to provide your physical and hand 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. 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/hand therapy and the plan the doctor and therapist have outlined for you. This means you will receive your therapy treatments as prescribed, 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 better reach your goals.

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 on to our website **www.sercttherapy.com**, then click on "medical library" and the appropriate body region and related article.

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

Attendance Policy

You have been referred here for treatment, and consistent attendance is a requirement both from a therapeutic standpoint and compliance standpoint. In the event you are unable to keep a scheduled appointment or participate in your program, you are to notify us prior to the scheduled appointment or program time.

For **Workers Compensation** patients, in instances of absence from rehabilitation, our clinic informs your insurance carrier, employer, and referring physician or rehabilitation nurse. If three consecutive absences occur without notification from you for the reason for absence, rehabilitation will be discontinued secondary to non-compliance in respect to attendance. Please understand that increased symptoms are not considered valid reasons for missing rehabilitation. If your symptoms increase, we especially need to have you present to address these symptoms and modify your program as indicated.

Patient Rights and Responsibilities

- The patient has the right to appropriate, considerate, and respectful care
- The patient has the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such actions
- The patient has the right to receive information necessary to give informed consent prior to the start of any procedure or treatment
- The patient has the right to treatment with respect, privacy, and dignity
- The patient has the right to receive a timely response to a request for service
- The patient has the right to be treated by qualified personnel who are experienced at the level of skills needed
- The patient has the right to reasonable continuity of care
- The patient has the right to be given reasonable notice of anticipated termination of services or of plans to transfer to another provider
- The patient has the right to discuss problems and suggest changes in goals or the care plan without fear of discrimination
- The patient has the right to be fully informed of the facility's policies and procedures
- The patient and the public have the right to honest, accurate, forthright information regarding outpatient rehabilitation services

SERC

Medical History/Subjective Information

Name: **Date:** **DOB:**

Home Phone: **Cell Phone:** **Work Phone:**

Primary Care Physician: **Referring Physician:**

Questions about your current condition:

1. When did your injury or symptoms first occur: (onset date) ____
2. How did your injury or symptoms first occur: ____
3. Have you had injections for this condition? Yes No If yes, how many:____when:______________helpful: Yes No
4. Have you had: X-ray MRI CT Scan Arthrogram Myelogram Bone Scan EMG
5. Have you seen another: Physical/Hand Therapist Chiropractor for this condition? Dates:___________to___________
6. If this is a back or neck injury, do you notice changes in your symptoms when coughing or sneezing? Yes No

Current Medications: (If you have a list of your current medications, please provide us a copy)

Name:____________________________Dosage:____________	Name:_________________________Dosage:______________
Name:____________________________Dosage:____________	Name:_________________________Dosage:______________

Surgical History/Hospitalization: (dating back one year)

Reason:____Approx. Date___________________

Reason:____Approx. Date___________________

General Medical History: Please check (√) if you have been diagnosed or experience any of the following.

Heart Condition	Respiratory Condition	Infectious Disease
High Blood Pressure	Asthma	Tuberculosis
Angina	Emphysema	AIDS
Coronary Artery Disease	Bronchitis	Hepatitis
Coronary Artery Bypass	COPD	MRSA
Myocardial Infarction	Pulmonary Emboli	Other
Pacemaker	Shortness of breath	
Stent(s)	Cough/Wheeze	

General Health

Cancer	Diabetes Type I	TIA's or Strokes	Seizures/Epilepsy/Convulsions
Smoker	Diabetes Type II	Unusual Fatigue	Unexplained Nausea/Vomiting
Arthritis	Rheumatoid Arthritis	Loss of Appetite	Unexplained Weight Loss/Gain
Dizziness	Osteoporosis	Severe Headaches	Fever or Night Sweats
Fainting	Pregnancy	Blurred Vision	Blood Thinner/Steroid Use
Frequent Falls	DVT (blood clot)	Ringing in Ears	Reactions to Medications
Balance Problems	Bowel/Bladder Control	Allergies	Latex Allergies

Functional Activities: Please check(√) any of the following activities that are difficult or cause symptoms to increase.

Getting in/out of chairs, beds, car shower	Caring for a dependent child or adult
Putting on shoes, shirts, jackets, pants, etc.	Walking on: Incline Flat Surface Uneven surface
Sitting or standing long periods of time	Climbing on: Stairs Ladders
Reaching overhead, behind back, down, forward	Recreational activities/sports
Housework (vacuum, laundry, mop, dust, make beds, yard work)	Driving a Vehicle
Sleeping through the night	Job Duties
Lifting Carrying Pushing Pulling	Gripping, holding tools, opening jars
Bending Squatting Kneeling	Picking up small objects
Balancing on one or both feet	Drinking or Eating (using utensils)

Have you completed a "Living Will" or "Durable Power of Attorney" Yes No Copy on file Yes No

SERC

PAIN DRAWING

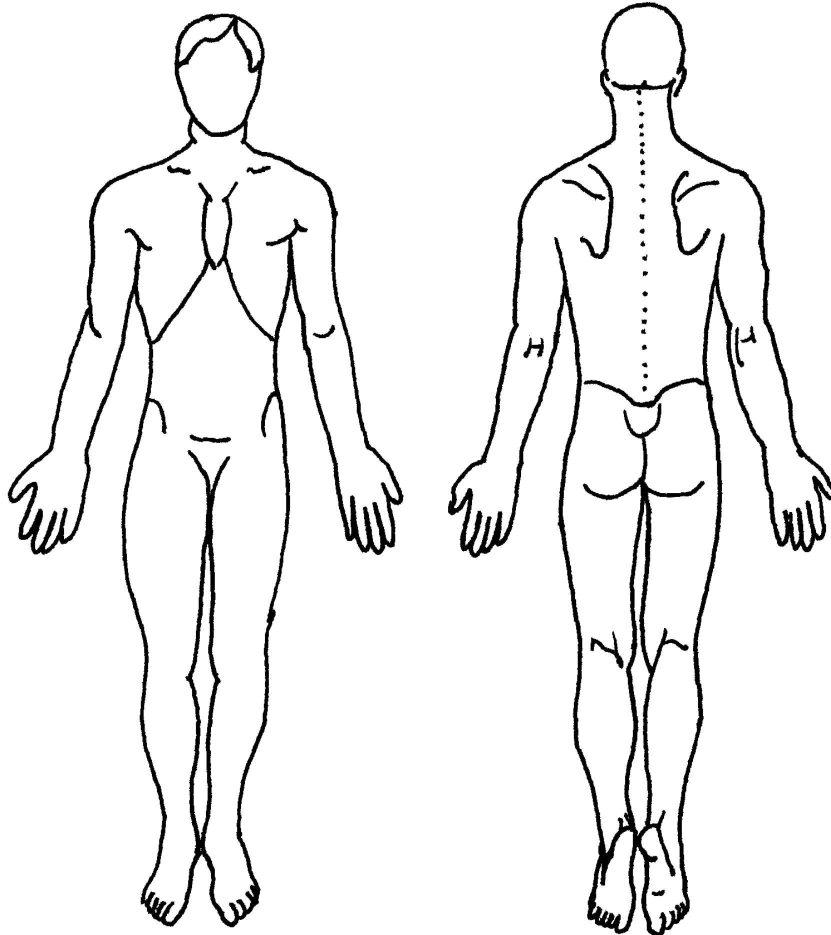
Name: ______________________ Date of Birth: ____________ Date: ____________

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

/// Stabbing	XXX Burning/Throbbing/Aching	OOO Pins and Needles	=== Numbness



Please rate your current pain using a 0 – 10 scale ______
(0 = no pain, 10 = extreme pain)
What has your pain level been at it's worst, _____ at it's best ______

SERC Physical & Hand Therapy

Informed Consent

Initial:

_____ **SERC Physical & Hand Therapy supports safe procedures throughout physical testing and treatment programs. If you have any questions or concerns, please discuss them with a staff member.**

The evaluation and treatment program involves procedures, involving strength, flexibility, endurance, cardiovascular fitness, material handling, coordination, static posturing, and repetitive movements.

There are certain inherent risks involved in any physical evaluation and rehabilitation program. Patients are asked to exert effort, handle weights, and perform activities with increasing degrees of difficulty. These risks may include, but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of your current condition is also possible. Any increase in your current level of discomfort, or any other change in your symptoms should be immediately reported to a staff member.

There are several benefits associated with testing. They include: confirmation of the present medical condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility and strength, improved cardiovascular endurance and coordination, and better circulation; all combining to improve function in activities of daily living.

Risk factors have been reduced to the best of our ability. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatment program.

Authorization to Release Information

Initial:

_____ 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, primary care physician, referring physician, employer*(Workers Compensation patients only)* 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 made available to me.(A copy is posted in our lobby for your convenience, or a copy will be provided to you if requested.)

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

______________________________		____________	____________
Patient's Signature		**DOB**	**Date**

______________________	____________	____________	____________
Signature of Responsible Party (if different than patient)	**Relationship**	**DOB**	**Date**

SERC Physical & Hand Therapy
Statement of Privacy Notice

Effective September 25, 2008

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 Physical & Hand Therapy (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 Physical & Hand Therapy
  ATTN: Patient Information Privacy Officer
  17134 Bel-Ray Place
  Belton, MO 64012
- 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 (913) 384-1642 or (816) 554-9559.