Somerset Rehabilitation Services

903 Route 202, Raritan, NJ 08869
Ph: (908) 725-1144 Fax: (908) 725-7173

BILL and VICKY KASSERMAN and their staff wish to welcome you to our office. We are very pleased to have you with us. Please review the following papers and answer these questions to help us become better acquainted. If you need any help, please do not hesitate to ask.

Consent for Care, Treatment and Privacy and Patient Information Practices

I, the undersigned, give my consent for **SOMERSET REHABILITATION SERVICES** to furnish medical care and treatment to Test Patient , considered necessary and proper in treating their prescribed condition. I understand the provicy policies of SOMERSET REHABILITATION SERVICESm PA

Patient, Parent or Guradian: Date:

Privacy of Patient Information Practices

This notice describes how your medical information may be disclosed. Please read it carefully. **SOMERSET REHABILITATION SERVICES, PA** is required by law to protect the privacy of your health information by providing this notice about our practices.

Uses and Disclosures

SOMERSET REHABILITATION SERVICES can use your personal information primarily for treatment, obtaining payment for treatment rendered, conducting internal administrative activities and evaluating the quality of care that we provide. We may use your information to contact you regarding appointment reminders, treatment alternatives or other health-related matters. We may use or disclose your personal health information without prior authorization for public health purposes, auditing purposes, emergencies, and when required by law. It is our policy to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. If changes are made to **SOMERSET REHABILITATION SERVICES** privacy policy, a new **PRIVACY OF PATIENT INFORMATION PRACTICES** will be posted and a copy given to you on your next visit.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal information at any time. You may request correction of any inaccurate or incomplete information in your records. You may request a list of instances where we may have disclosed your information. You may request in writing that we do not use or disclose your personal health information for any reason if you disagree with any decisions made regarding access or disclosure of said information. We will consider all requests on a case-by-case basis, however we are not legally bound to accept them.

Concerns and Complaints

If you are concerned that **SOMERSET REHABILITATION SERVICES** may have violated your privacy rights or if you disagree with any decisions made regarding your personal health information, please contact our Office Manager. You may also send a written complaint to the **U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES.**

PATIENT INFORMATION CONSENT FORM

I have read and fully understand **SOMERSET REHABILITATION SERVICE'S** Notice of Information Practices.

I understand that **SOMERSET REHABILITATION SERVICES** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how may personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **SOMERSET REHABILITATION SERVICES** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **SOMERSET REHABILITATION SERVICE'S** Notice of Information Practices, which includes releasing any information necessary to process my insurance claim. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I understand a copy of the "Notice of Patient Information Practices" is available for me upon request.

I authorize payment of medical benefits directly to **SOMERSET REHABILITATION SERVICES** for services rendered. My signature serves also as my assignment of benefits. Should enforcements be necessary for collection of the bill, collection fees of 30% or $50.00, whichever is greater will be my responsibility. I understand that all payment for services rendered are due in 45 days and I am responsible for all charges not processed or paid by my insurance. I understand that copays are required upon arrival. If applicable, I also direct my attorney to pay **SOMERSET REHABILITATION SERVICES** FIRST, DIRECTLY and IN FULL. I agree, in order for the facility to service my account or to collect any amounts I may owe, **SOMERSET REHABILITATION SERVICES** may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device, as applicable.

*** PLEASE CALL 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT TO CANCEL IN ORDER TO AVOID A $25 CANCELLATION FEE!**

William Kasserman, PT
Victoria Kasserman, PT
Wendy Dwyer, MSPT

OMERSET REHABILITATION SERVICE

Phone: (908)725-1144
Fax: (908)725-7173

Email: info@somersetrehab.com

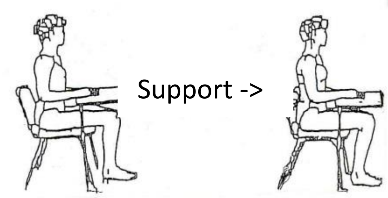
Welcome to Somerset Rehabilitation Services!

Please discuss the body alignment positions shown below with your therapist.

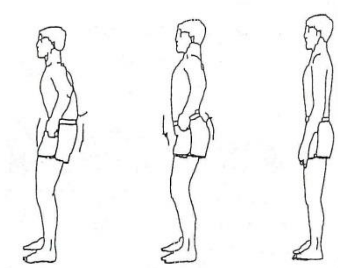
We look forward to working with your to obtain optimum outcome from your rehabilitation program. **In order to receive your maximum benefit, it is most important that you attend your therapy sessions and follow your home program.** Your participation with your home exercise program, proper posture and body mechanics will assist in your recovery.

Posture

When in **good alignment**, weight is evenly distributed through the spine, making back injuries less likely to occur.
When in **poor alignment**, excessive stress is placed upon the facet joints, discs, ligaments and muscles of the spine.

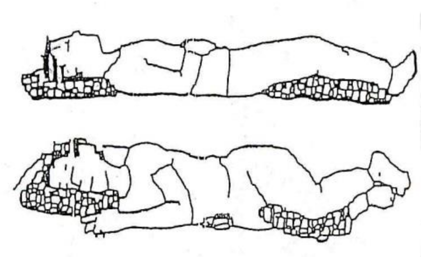


Sitting Posture:
Slide buttocks to the back of the seat. Place a lumbar roll to support the lumbar lordosis. Keep ears in line with shoulders. When sitting in a chair, both feet should reach the floor. Hips should be a 90° angle.



Standing Posture:
Imagine a plumb line beside your body. If your ears, shoulder, pelvis, knees and ankles line up on the line, you are in good alignment.

Sleeping Posture:
It is impossible to control your sleeping posture throughout the night; however, you can begin in a good position to avoid stress on the back and find a comfortable, pain-free position in which to fall asleep. If you choose to lie on your back, use one pillow under your head and place several pillows under your knees. If you lie on your side, use one pillow under your head and one pillow between your knees.



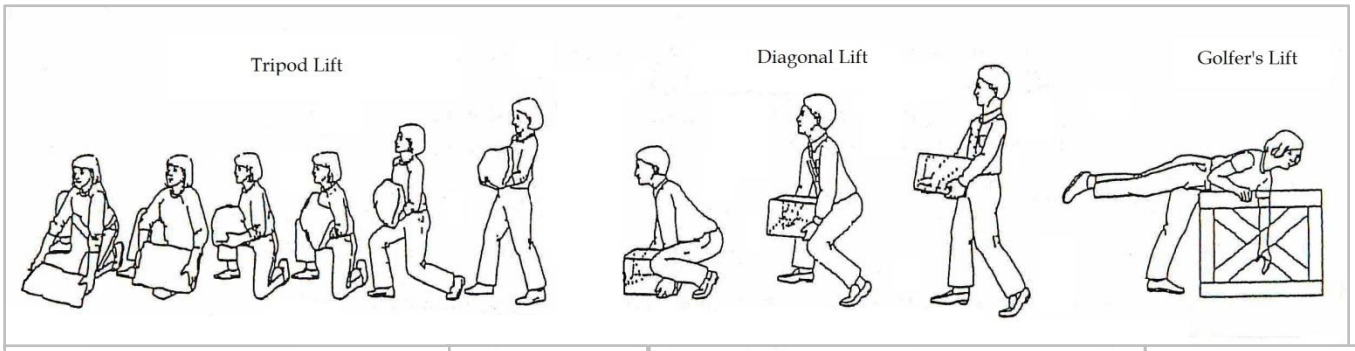
2 or 3
Pillows

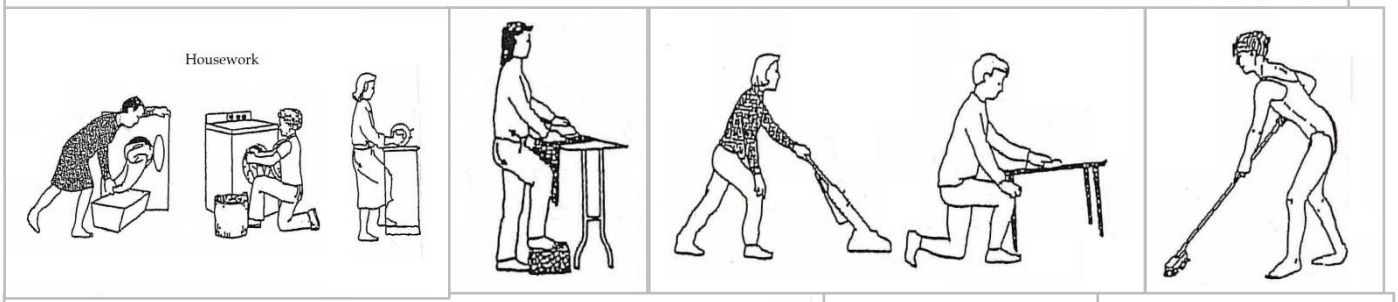
(Turn over for more body alignment positions)

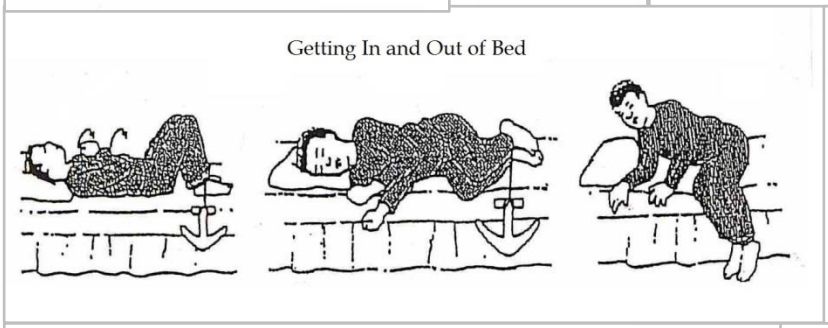
Maintain the curves of your spine and use proper body mechanics during your daily activities to avoid exacerbation of your symptoms and future injury.

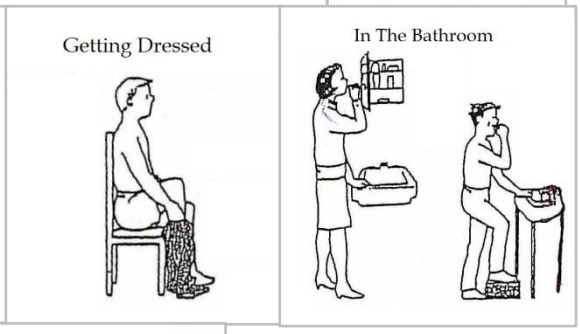
Lifting:

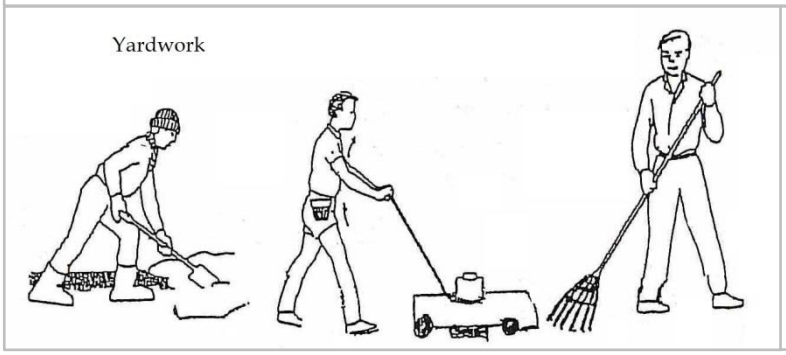
Bend your knees, tighten your stomach muscles, lift with your legs, keep load close, keep your back upright and use one of the following lifting techniques:

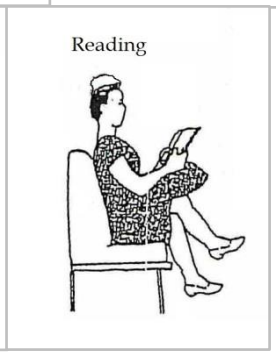












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OUTPATIENT MEDICAL HISTORY / SCREENING FORM

Patient Name: _____ **Occupation**: _____
Age: _____ **Known Allergies** :_____
Email:_____

IN CASE OF EMERGENCY: _____ **PHONE**: _____

Medical Information: Please Checkif you have had any of the following conditions.

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ History of Smoking
- ☐ Lung Problems
- ☐ Asthma
- ☐ Diabetes
- ☐ Dizziness / Headaches
- ☐ Fainting Disorders
- ☐ Anxiety / Panic Attacks
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Fractures
- ☐ Hernia
- ☐ Thyroid Problems
- ☐ Seizures
- ☐ TMJ Disorders
- ☐ Chills / Night Sweats
- ☐ Swelling of Extremities
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Lyme's Disease
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Bladder Incontinence
- ☐ Bowel Incontinence
- ☐ Vomiting / Diarrhea
- ☐ Unexplained Weight Loss
- ☐ Stroke
- ☐ Other: _____

Are you or could you be pregnant? ☐Yes ☐No

Have you been having an increased incidence of falls? ☐Yes ☐No

Have you had any surgeries? ☐Yes ☐No

If so, Type and Date of Surgery (if applicable): _____

Have you had any X-Rays, MRIs or CT Scans related to your current condition? ☐Yes ☐No

If so, What: _____

Rate your pain associated with this condition (circle one): (no pain) **0 1 2 3 4 5 6 7 8 9 10** (severe pain)

Current Medications (Prescription or Over the Counter) :_____

_____

What are your treatment goals? :_____

_____

Patient Signature :_____ Date :_____

Therapist Signature : _____ Date: _____

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Aquatic Program Patients

POOL TEMPERATURE 87˚ TO 92˚F POOL DEPTH 4 ½ TO 6 FEET
JACUZZI TEMPERATURE 100˚ TO 104˚F

- PLEASE SHOWER BEFORE ENTERING POOL
- NO DIVING
- CAUTION: WET FLOOR..ALWAYS WEAR APPROPRIATE FOOTWEAR IN ALL AREAS.

TO PROTECT PATIENT'S HEALTH, CONTRAINDICATIONS MUST BE FOLLOWED:

	YES	NO
BOWEL/BLADDER INCONTINENCE, ABSORBENT PADS, DIAPERS, COLOSTOMY BAG OR CATHETER, MEDICATIONS USED FOR ANY OF THESE CONDITIONS? IF YES, PLEASE EXPLAIN _____	___	___
OPEN WOUNDS OR SURGICAL SITE NOT FULLY CLOSED?	___	___
POOL CHEMICAL ALLERGIES I.E. BROMINE, CHLORINE?	___	___
INFECTIOUS DISEASE (TB, HEPATITIS, OTHER)?	___	___
CONTAGIOUS SKIN CONDITIONS?	___	___
ILLNESS WITH FEVER?	___	___
SEVERE HEART, BLOOD PRESSURE OR LUNG DISORDERS?	___	___
MULTIPLE SCLEROSIS?	___	___

BALANCE PROBLEMS/DIZZINESS? ___ ___

PREGNANT? ___ ___

AFRAID OF WATER? ___ ___

CAN YOU SWIM? ___ ___

CAN YOU ENTER POOL INDEPENDENTLY? ___ ___

TELL THERAPIST IF YOU ARE MENSTRUATING OR IF THERE ARE CHANGES IN YOUR MEDICAL STATUS OR MEDICATIONS.

I UNDERSTAND AND WILL COMPLY WITH ALL RULES OF THE POOL

_____ _____

PATIENT SIGNATURE DATE