

SpineCenterAtlanta

REHABILITATION, AQUATIC AND WELLNESS CENTER

Patient's Name: _____

Date: _____

Nombre del Paciente

Fecha

PAST MEDICAL HISTORY ▪ HISTORIAL MEDICO

Do you have any medical problems? (i.e. high blood pressure, diabetes, cancer, high cholesterol, asthma, heart problems, kidney problems, lung problems, stomach ulcers, stroke) List below:

Padece usted alguna enfermedad? (ejemplo: presión arterial alta, diabetes, cáncer, colesterol alto, asma, problemas del corazón, problemas de riñón, úlceras, problemas de los pulmones, infarto) Enlístelos a continuación:

| CONDITION ▪ CONDICION | TREATED BY (PHYSICIAN) ▪ ATENDIDO POR (NOMBRE DEL MEDICO) |
|------------------------------|--|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

SURGICAL HISTORY ▪ HISTORIAL QUIRURGICO

Please list all surgeries in your lifetime including childhood surgeries (i.e. tonsils, appendix):

Mencione todas las cirugías que ha tenido en su vida incluyendo las de su infancia (Ej.: apéndice, anginas):

| SURGERY ▪ CIRUGIA | DATE ▪ FECHA | PHYSICIAN ▪ MEDICO |
|--------------------------|---------------------|---------------------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

MEDICATIONS ▪ MEDICAMENTOS

Please list all medications and the prescribing physician:

Mencione todos los medicamentos que toma y el medico que los prescribe:

| MEDICATIONS AND DOSE MEDICAMENTOS Y DOSIS | PRESCRIBING PHYSICIAN MEDICO QUE LAS PRESCRIBE |
|--|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |

SpineCenterAtlanta
REHABILITATION, AQUATIC AND WELLNESS CENTER

SpineCenterAtlanta
Rehabilitation, Aquatic and Wellness Center
3161 Howell Mill Rd NW Suite 410 • Atlanta, GA 30327
Tel 404.352.4200 • Fax 404.352.5200

INFORMACION QUE USTED NECESITA SABER

- Le pedimos de la manera mas atenta que en caso de requerir hacer un cambio en sus citas, nos lo comunique por lo menos con 24 hrs. de anticipación a su cita. Debido a que no programamos mas de un paciente a la vez, esto nos permite brindarle una terapia de 1 a 1, mas personalizada que en la mayoría de otras facilidades de terapia. Las cancelaciones hechas el mismo día de su cita y/o el no presentarse a su cita, impiden la posibilidad de ofrecerle ese espacio a algún otro paciente.
- Los pacientes que frecuentemente estén faltando a sus citas serán dados de baja de la terapia física y referidos con su doctor para su consideración y la decisión sobre su tratamiento. No se pueden observar resultados positivos de la terapia física si su asistencia es irregular.
- Estamos requeridos de notificar a los empleadores cuando un paciente de WORKER'S COMPENSATION no atiende a su sesión de rehabilitación. El no presentarse en repetidas ocasiones a sus sesiones de terapia puede afectar sus beneficios de WORKERS COMPENSATION y su relación con su empleador.
- Por favor haga todo lo posible por llegar a su cita a tiempo. A los pacientes que lleguen con mas de 15 minutos de retraso y afecten a otros pacientes por su demora, o al programa de terapia, se les cancelara su cita solicitándoles programar otra nueva cita.
- Como una CORTESIA al paciente, la administración del edificio nos ha permitido brindarle UNA ficha de estacionamiento GRATIS por semana. Efectivo desde Julio 1, 2008, las compañías que son contratadas para el transporte de pacientes, a través de la cobertura de Worker's Compensation, están LIMITADOS a UNA ficha GRATIS por pacientes por semana. Para evitar que las compañías de transporte tengan que pagar por cuotas de estacionamiento, se les sugiere que dejen/recojan a los pacientes en la entrada del estacionamiento en la calle de DOWNWOOD CIRCLE. No podemos ofrecer excepciones a esto ya que esta política esta dictada por la administración del edificio.
- La comunicación es muy importante entre el paciente y el personal para así asegurar una experiencia positiva en el SpineCenterAtlanta. Por favor nunca dude en comunicar al personal sus dudas o preocupaciones para que así, nosotros podamos servirle mejor y atender a sus necesidades para su rehabilitación!

LE DAMOS LA BIENVENIDA AL SpineCenterAtlanta: Rehabilitación, Aquatic and Wellness Center. LE AGRACEDEMOS EL QUE NOS HAYA PERMITIDO ATENDER A SUS NECESIDADES PARA SU REHABILITACION.

Firma: _____
Nombre: _____
Fecha: _____

AUTORIZACION PARA TRATAMIENTO, ADVERTENCIAS, REGLAS Y DECLARACIONES

ADVERTENCIA!

Este es un Centro de Terapia Física. Únicamente serán atendidos aquellos pacientes referidos por un profesional de la salud. Mediante la firma de esta forma, usted certifica ser mayor de 18 años de edad. Solo se permite el acceso a este centro a los pacientes del mismo y durante el horario de operación del centro (8:00am a 6:00pm). Es responsabilidad del paciente el conocer los horarios de operación. No se permite el acceso a menores de edad sin supervisión, a ninguna de las áreas de este centro por lo cual deberán esperar a sus familiares únicamente en las áreas destinadas para uso común. Todos los miembros de este centro deberán ser aprobados previamente por su médico tratante para participar en las actividades asociadas con el centro de terapia física. Lo anterior no es responsabilidad del centro. Mediante su firma al calce, usted reconoce y libera a esta facilidad, su personal, dueños, directores y afiliados de cualquier responsabilidad por lesiones sufridas en la práctica de actividades físicas dentro de esta facilidad.

PRECAUCION

Usted realizara los ejercicios y usara el equipo bajo su propio riesgo. Existen maquinas para ejercicio cardiovascular que pueden ser peligrosas, algunas maquinas con poleas, engranes, cables y bandas que pueden causar lesiones. (Usted deberá escuchar las instrucciones apropiadas antes del uso de cualquier maquina, aparato o pesas en este centro). Entienda que hay pesas dentro de esta facilidad las cuales de ser usadas indebidamente pueden ponerlo en riesgo de una lesión. Así mismo, existen riesgos extremos asociados con la sala de terapia de grupo. La participación en clases de terapia de grupo, podrían generar lesiones o inclusive causar la muerte. (recomendamos poner especial atención en el uso del equipo para estas terapias). Usted como paciente será responsable de verificar el buen estado y funcionamiento del equipo y sus componentes, pesas, aparatos cardiovasculares o equipo usado para acondicionamiento de grupo. En reconocimiento de los posibles peligros, el riesgo de la transmisión de fluidos corporales e inclusive la muerte relacionada con cualquier actividad física, por medio del presente, usted voluntariamente y con conocimiento renuncia a todos los derechos de causa y acción de cualquier tipo, que resultaran de cualquiera de estas actividades, incluyendo clases de terapia de grupo de las cuales pudiera desprenderse alguna acción de responsabilidad hacia el centro, sus empleados, dueños, directores, afiliados y terapistas.

ASI MISMO

El uso de vestidores, baños, regaderas y/o piscina (regulaciones y reglas de uso publicadas) pudieran ser peligrosas y provocar lesiones (ejemplo: caídas, tropezones y/o resbalones en superficies resbalosas). Usted deberá entender leer y entender las reglas de la piscina, asumiendo total responsabilidad por sus acciones. Por favor lea cuidadosamente las reglas publicadas en el área de la piscina. No hay salvavidas presentes. Si usted no entiende claramente las reglas, solicite al personal su explicación.

INFORMACION ADICIONAL

Este centro opera en horario de oficinas y a ciertas horas las instalaciones no cuentan con supervisión y pueden ser peligrosas. Es su responsabilidad conocer estos horarios. Su presencia en horarios fuera de supervisión pudiera provocar lesiones e inclusive la muerte, por lo tanto usted debe entender que su presencia en estos horarios será bajo su propio riesgo, asumiendo usted total responsabilidad liberando a este centro por cualquier daño sufrido durante estas horas. Ningún paciente deberá permanecer en las áreas de terapia-tratamiento cuando el especialista con licencia no este presente.

Mediante la firma al calce, yo acepto y entiendo las reglas anteriores, regulaciones, declaraciones y advertencias, por lo tanto estoy de acuerdo y autorizo al personal clínico del Spine Center Atlanta para proveerme de cuidados, los cuales pueden incluir un examen físico y el contacto físico apropiado de mi persona con uno o mas de los miembros del personal durante el transcurso de cada sesión de terapia.

Firma de Aceptación: _____

Nombre: _____

Fecha: _____

ORIENTACION PARA PACIENTES EN REHABILITACION ACUATICA

ORIENTACION PREVIA A LA TERAPIA EN LA PISCINA

1. Traiga su(s) propia(s) toalla(s).
2. Tenemos casilleros a su disposición, pero les recomendamos que guarden sus objetos de valor en su auto o preferiblemente dejarlos en casa. Usted puede cambiarse la ropa en el área de los casilleros.
3. Usted puede usar su traje de baño debajo de su ropa de vestir para ganar tiempo previo a sus terapia.
4. Se requiere que tomen una ducha ANTES de entrar a la piscina (así remover cremas, lociones, etc.).
5. No se le permitirá participar en ejercicios acuáticos por ninguno de los siguientes motivos: cortadas/heridas abiertas, infección de la piel, catéteres, incontinencia, infecciones (gripe, infecciones gastro-intestinales, de vías urinarias/vejiga, o de la garganta). Se les requiere a los pacientes que contacten al SpineCenterAtlanta Rehabilitation, Aquatic and Wellness Center al teléfono 404 352-4200 si se encuentran enfermos o si tienen alguna duda o preocupación.
6. Deberá traer zapatos para el área de la piscina, para prevenir caídas. Pueden usar zapatos de agua dentro del área de la piscina. Le sugerimos el uso de zapatos para la piscina o para surf, sandalias con suela de goma o tenis (que no se usen para caminar y que no tengan suela negra)
7. Los clientes de la TERAPIA FISICA NO deben entrar a la piscina hasta que el terapeuta este presente.

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NUTRITIONAL QUESTIONNAIRE ▪ CUESTIONARIO NUTRICIONAL

Name (*nombre*): _____ Phone (*teléfono*): _____
Address (*dirección*): _____ City (*ciudad*): _____
State (*estado*): _____ Zip (*código postal*): _____
Physician (*medico*): _____

Please answer the following questions as accurately as possible
Por favor conteste las siguientes preguntas lo mas especifico posible.

1. Are you currently taking vitamins, minerals, nutritional supplements or herbal therapies?
Esta usted tomando vitaminas, minerales, suplementos nutricionales o terapias herbales?

Yes/Si

No

If yes, please list: ▪ *Si su respuesta es SI, menciónelas:* _____

2. Do you have any known sensitivities to vitamins, minerals, or herbs?
Sabe usted si, tiene alguna sensibilidad a las vitaminas, minerales o hierbas?

Yes/Si

No

If yes, please list: ▪ *Si su respuesta es SI, menciónelas:* _____

3. Are you currently taking any prescription medication?
Esta usted tomando algún medicamento prescrito?

Yes/Si

No

If yes, please list: ▪ *Si su respuesta es SI, menciónelas:* _____

4. Is it important for you to have access to more information about vitamins address your personal health concerns as advised by your physician?
Es importante para usted el tener acceso a mas información acerca de las vitaminas, aclaración a sus dudas respecto a su salud como fue recomendado por su medico?

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Yes/Si

No

Por favor marque los síntomas/preocupaciones de salud que apliquen en su caso.

| | | |
|--|--------------------------------|--|
| <i>Enfermedad de Alzheimer</i> | <i>Demencia</i> | <i>Hiper-lipidemia</i> |
| <i>ansiedad</i> | <i>Depresión, leve</i> | <i>Insomnio</i> |
| <i>Artritis u Osteoartritis</i> | <i>Dismenorrea</i> | <i>Dolor o rigidez en las articulaciones</i> |
| <i>Arteriosclerosis</i> | <i>Fatiga</i> | <i>Bajo nivel de energía.</i> |
| <i>Perdida de masa ósea</i> | <i>Retención de líquidos</i> | <i>Degeneración macular (vista)</i> |
| <i>Uñas o cabello quebradizo</i> | <i>Salud/Bienestar General</i> | <i>Perdida de la memoria</i> |
| <i>Cáncer</i> | <i>Enfermedad del corazón</i> | <i>Menopausia</i> |
| <i>Cataratas</i> | <i>Colesterol alto</i> | <i>Osteoartritis</i> |
| <i>Enfermedad arterial coronaria</i> | <i>Bochornos</i> | <i>Osteoporosis</i> |
| <i>Enfermedad degenerativa de las articulaciones</i> | <i>Hipercolesterolemia</i> | <i>Enfermedad vascular periférica</i> |
| <i>Síndrome Pre-menstrual</i> | <i>Embarazo</i> | <i>Estrés</i> |

Please check the health concerns/symptoms that apply to you.

| | | |
|----------------------------|-------------------------|---------------------------------|
| Alzheimer's Disease | Dementia | Hyperlipidemia |
| Anxiety | Depression, mild | Insomnia |
| Arthritis (Osteo) | Dysmenorrhea | Joint pain/stiffness |
| Artherosclerosis | Fatigue | Low energy levels |
| Bone Loss | Fluid retention | macular degeneration(eye sight) |
| Brittle nails or hair | General Health/Wellness | Memory loss |
| Cáncer | Heart Disease | Menopause |
| Cataracts | High cholesterol | Osteoarthritis |
| Coronary Artery Disease | Hot Flashes | Osteoporosis |
| Degenerative Joint Disease | Hypercholesterolemia | Peripheral Vascular Disease |
| PMS | Pregnancy | Stress |

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NOTIFICACION DE PRACTICAS DE PRIVACIDAD

A nuestros pacientes. Esta notificación describe como la información, acerca de usted (como paciente de esta practica), puede ser usada y divulgada, y como puede usted obtener acceso a su información de salud. Esto es requerido por las regulaciones de privacidad creadas como resultado del Health Insurance Portability and Accountability Act de 1996 (HIPAA) (Ley de Manejo y Responsabilidad en los Seguros de Salud, de 1996)

Nuestro Compromiso con su Privacidad

Nuestra practica esta dedicada al mantenimiento de privacidad de su información de salud. Nosotros estamos obligados por la ley a mantener la confidencialidad de su información de salud. Nosotros comprendemos que estas leyes son complicadas, pero es nuestro deber proveerle a usted de la siguiente información importante:

Uso y divulgación de su información de salud bajo ciertas circunstancias especiales

Nosotros estaríamos obligados a revelar su información de salud bajo las siguientes circunstancias:

- 1) A las autoridades de salud publica y agencias de vigilancia de salud autorizadas por la ley para recabar información.
- 2) Como respuesta a una orden administrativa o de la corte en casos de demandas o procesos similares.
- 3) A solicitud de un oficial de las fuerzas del orden.
- 4) Cuando sea necesario para reducir o prevenir una amenaza seria a su salud y seguridad, a la de otro individuo o a la del publico en general. En cuyo caso nosotros únicamente divulgaremos la información a la persona u organización competente para ayudar a prevenir esta amenaza.
- 5) Si usted es miembro de las Fuerzas Militares de los Estados Unidos o extranjeras (incluyendo veteranos), siempre y cuando estas sean requerida por las autoridades apropiadas.
- 6) Agentes federales en caso de ser autorizado por la ley con propósitos de seguridad nacional o inteligencia.
- 7) A instituciones de correccional u oficiales del orden publico en caso de ser usted un recluso o estar bajo la custodia de un oficial del orden publico.
- 8) Para programas de compensación al trabajador y programas similares.

Sus derechos en cuanto a su información de salud

- 1) Comunicaciones. Usted puede solicitar a esta practica el envío de comunicaciones acerca de su información de salud y asuntos relacionados, de una manera particular o en cierta dirección especifica. Por ejemplo, usted podría solicitar preferentemente ser contactado en casa o en el trabajo. Nosotros cumpliremos con aquellos requisitos razonables.

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- 2) Usted puede solicitar una restricción en el uso o divulgación de la información de salud para su tratamiento, pago o manejo del cuidado de su salud. Adicionalmente, usted tiene el derecho de solicitar que nosotros restrinjamos la divulgación de su información de salud, únicamente a ciertos individuos involucrados en su cuidado o el pago de sus cuidados. Estas restricciones pueden incluir a miembros de su familia y amigos. Nosotros no estamos obligados a acceder a sus peticiones; sin embargo, si nosotros accedemos estaremos obligados a cumplir este acuerdo excepto bajo requerimientos legales, en emergencias o cuando la información sea necesaria para su tratamiento.
- 3) Usted tiene el derecho de revisar y obtener copia de la información de salud que pueda ser usada para la toma de decisiones respecto a usted, incluyendo sus registros médicos como paciente y registros de pagos, sin incluir notas de psicoterapia. Usted puede someter su solicitud por escrito dirigiéndola a Orthopaedic and Spine Surgery of Atlanta, atención office manager, 404-351-5812.
- 4) Usted puede solicitarnos se hagan correcciones a su información de salud si usted cree que esta es incorrecta o incompleta siempre y cuando esta información este bajo custodia de nuestra practica o para el uso de la misma. Para solicitar correcciones usted deberá hacer una solicitud por escrito y someterla a Orthopaedic and Spine Surgery of Atlanta, a la atención del Administrador de la Oficina, al teléfono 404-351-5812. Usted deberá informar de la razón que apoye esta solicitud de correcciones.
- 5) Derecho de recibir una copia de esta notificación. Usted tiene el derecho de recibir una copia de esta notificación de practicas de privacidad. Usted podrá solicitarnos una copia de esta notificación en cualquier momento. Para obtener una copia de esta notificación contacte a nuestra recepcionista.
- 6) Derecho de presentar una queja. Si usted cree que sus derechos de privacidad han sido violados, usted puede presentar una queja en nuestras oficinas o con el Secretario del Departamento de Salud y Servicios Humanos. Para presentar una queja en nuestra oficina, contacte a Orthopaedic and Spine Surgery of Atlanta, a la atención del Administrador de la oficina, al teléfono 404-351-5812. Todas las quejas deberán ser sometidas por escrito. Usted no será penalizado por presentar una queja.
- 7) Derecho de otorgar una autorización para otros usos y divulgaciones. Nuestra práctica solicitara su autorización por escrito para usos y divulgaciones que no estén identificadas por esta notificación o que sean permitidas por la ley vigente.

Si usted tiene cualquier pregunta en relación a esta notificación, o de nuestras políticas de privacidad de su información de salud, por favor contacte a Orthopaedic and Spine Surgery of Atlanta, . a la atención del Administrador de la oficina, al teléfono 404-351-5812

Por la presente reconozco que he sido presentado con una copia de las notificación de las Políticas de las Practicas de Privacidad del Orthopaedic and Spine Surgery of Atlanta.

Firma: _____
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PATIENT INFORMATION FORM ▪ FORMATO DE INFORMACION DE PACIENTE

Date (fecha): _____
Name (nombre): _____ Sex (sexo): M _____ F _____
Address (dirección): _____ Apt # (# apartamento): _____
City (ciudad): _____ State (estado): _____ Zip (código postal): _____
Phone (teléfono): _____ Cell phone # (# teléfono celular): _____
Email (correo electrónico): _____
Birthdate (fecha de nacimiento): _____ Age (edad): _____
Marital Status (estado civil): _____ Social Security (seguro social): _____
Employer (empleador): _____ Occupation (ocupación): _____
Address (dirección): _____ Phone (teléfono): _____
Alt. # (numero alterno): _____

Emergency Contact Person (contacto en caso de emergencia) _____
Telephone (different from # above) (teléfono diferente al #. anterior): _____
Relationship to you (relación): _____ Address (dirección): _____

Who referred you to our office? (Quien lo refirió a esta oficina?): _____
Attorney name, number, address (if any) (nombre del abogado, teléfono, dirección (si aplica))

Have you been treated for this condition elsewhere? ▪ *Ha sido atendido por esa condición en algún otro consultorio?*
Yes/Si _____ No _____

If yes, where and by whom?: ▪ *Si su respuesta es Si, en donde y por quien?:*

Is your visit related to an auto accident or work injury? ▪ *Su visita es relacionada con un accidente vehicular o lesión en el trabajo?*
Yes/Si _____ No _____

If yes, what date did the accident or injury occur?: ▪ *Si su respuesta es Si, en que fecha ocurrió este accidente o lesión?:*

Did this happen at work? ▪ *Esto sucedió en el trabajo?*
Yes/Si _____ No _____

Did this happen as a result of an auto accident? ▪ *Esto sucedió como resultado de un accidente vehicular?*
Yes/Si _____ No _____

If yes, where did the accident take place?: ▪ *Si su respuesta es Si, en que fecha ocurrió el accidente?:*

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Name (nombre): _____ Date (fecha): _____

Are you allergic to any medications? (Es usted alérgico a algún medicamento?) Yes/Si ____ No ____

If yes, please list medication and type of reaction you have. (Si respondió SI, mencione que medicamentos y el tipo de reacción que presenta).

1. _____

2. _____

SURGICAL HISTORY ▪ HISTORIAL QUIRURGICO

Do you smoke? ▪ Fuma? Yes/Si ____ No ____

If yes, how long? ▪ Si respondió SI, desde cuando? _____ Years (años)

How many packs a day ▪ Cuantas cajetillas al día? _____

Have you ever smoked? ▪ Alguna vez ha fumado? Yes/Si ____ No ____

If yes, how long? ▪ Si respondió SI, por cuanto tiempo? _____ Years (años)

How many packs a day? ▪ Cuantas cajetillas al día? _____

When did you quit? ▪ Cuando dejo de fumar? _____

Do you drink alcohol? ▪ Bebe alcohol? Yes/Si ____ No ____

If yes, circle one ▪ Si respondió SI, circule una respuesta::

Daily
(diario)

Occasionally
(ocasionalmente)

Socially
(eventos sociales)

Rarely
(casi nunca)

Do you use illicit drugs? ▪ Usa alguna droga ilícita? Yes/Si ____ No ____

If yes, what substance? ▪ Si respondió SI, que sustancia? _____

Name of the company you work for: ▪ Nombre de la compañía para quien trabaja: _____

Position (puesto): _____

Are you working at this time? ▪ Esta usted trabajando en este momento? Yes/Si ____ No ____

If no, date of last day worked: ▪ Si respondió NO, cuando fue el ultimo día que trabajo? _____

Are you (es usted):

Single
(soltero)

Married
(casado)

Divorced
(divorciado)

Widowed
(viudo)

Separated
(separado)

Do you have any children? ▪ Tiene hijos? Yes/Si ____ No ____

If yes, how many? ▪ Si respondió SI, cuantos hijos tiene? _____

FAMILY HISTORY ▪ HISTORIAL FAMILIAR

Mother (madre): ____ Living (viva) ____ Diseased (finada) Age (edad) ____ Age of death (edad al fallecer) _____

Reason for death or other health problems? (i.e. diabetes, high blood pressure, cancer, asthma, heart attack, stomach ulcers, stroke) Please list: ▪ Motivo de fallecimiento u otros problemas de salud?

Ejemplo: diabetes, presión alta, cancer, asma, infarto, ulceras. Por favor mencione:

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Father (*padre*): _____ Living (*vivo*) _____ Diseased (*finado*) Age (*edad*) _____ Age of death (*edad al fallecer*) _____

Reason for death or other health problems? (i.e. diabetes, high blood pressure, cancer, asthma, heart attack, stomach ulcers, stroke) Please list: ▪ *Motivo de fallecimiento u otros problemas de salud? Ejemplo: diabetes, presión alta, cancer, asma, infarto, ulceras. Por favor mencione:*

Siblings (*hermanos*):

Number of sisters ▪ *Cuántas hermanas*: _____ Number of brothers ▪ *Cuántos hermanos?*: _____

Any health problems (i.e. diabetes, high blood pressure, cancer, asthma, stomach ulcers) Please list: ▪ *Padecen algún problema de salud? Ejemplo: diabetes, presión alta, cancer, asma, infarto, ulceras, stroke. Por favor mencione:*

Patient's Signature (*firma del paciente*): _____

WAIVER OF RESPONSIBILITY

It is agreed and understood that all activities, exercises, use of equipment and facilities shall be undertaken by the undersigned at his/her sole risk, and SpineCenterAtlanta, Rehabilitation, Aquatic and Wellness Center shall not be liable for any claims, demands, injuries, damages, actions or causes of action to the undersigned arising out of or connected with the use of any of the services and or facilities. The undersigned forever expressly releases, indemnifies and holds harmless SpineCenterAtlanta, Rehabilitation, Aquatic and Wellness Center, affiliated corporations and organizations, their owners, agents and employees from any and all liability, whatsoever.

Signature: _____ Date: _____
Name : _____
Address: _____ City: _____
State: _____ Zip Code: _____
Telephone: (____) _____ - _____

LIBERACION DE RESPONSABILIDAD

Queda entendido y acordado que todas las actividades, ejercicios, uso de las instalaciones y equipo serán responsabilidad de quien suscribe y se realizaran bajo su propio riesgo. SpineCenterAtlanta Rehabilitation, Aquatic and Wellness Center no será responsable por ninguna reclamación, demanda, lesión, daño, acción, o causa que resulte del uso de cualquiera de los servicios y/o instalaciones del centro. El que suscribe libera expresamente y sin limitación, indemniza y libera de todo daño al SpineCenterAtlanta Rehabilitation, Aquatic and Wellness Center, sus corporaciones afiliadas y organizaciones, sus propietarios, agentes y empleados quienes no serán sujetos de ninguna responsabilidad.

Firma: _____ Fecha: _____
Nombre: _____
Dirección: _____ Ciudad: _____
Estado: _____ Código Postal: _____
Teléfono: (____) _____ - _____

Notificación sobre Asistencia

Se recomienda a los pacientes mantener las citas programadas. La terapia física y la rehabilitación es efectiva UNICAMENTE cuando el paciente toma participación activa en su cuidado y recuperación. Lo anterior requiere su asistencia regular a la terapia como su medico lo ha indicado y como lo recomiende el terapeuta que atiende su caso.

Nosotros reprogramaremos sus citas con gusto, siempre y cuando usted haya informado a esta oficina por lo menos con 24 horas de anticipación. Esto nos brinda la oportunidad de ofrecer los espacios disponibles a algún otro paciente/cliente.

Por favor lea Las Políticas de Asistencia de SpineCenterAtlanta a descritas continuación:

- Todos los pacientes cubiertos bajo los beneficios de Compensación al Trabajador (Worker's Compensation) deberán atender a TODAS sus sesiones de terapia. Si usted falta a su cita, nosotros nos vemos obligados a contactar al ajustador y/o a la enfermera a cargo de su caso para reportar la inasistencia. El faltar a sus citas puede afectar sus beneficios de acuerdo a las reglas y regulaciones del programa de Compensación al Trabajador (Worker's Compensation) y podría poner en riesgo la aprobación de las sesiones de terapia. CUALQUIER PACIENTE QUE FALTE A 3 SESIONES DE TERAPIA SIN JUSTIFICANTE MEDICO SERA DADO DE BAJA POR INCUMPLIMIENTO, NOTIFICANDO AL MEDICO TRATANTE. Por favor proteja sus beneficios de Compensación al Trabajador (Worker's Compensation) planeando con anticipación de manera que no falte a sus citas.
- Todos los pacientes cubiertos por un seguro de gastos médicos privado o un seguro de grupo serán requeridos de atender a todas sus sesiones de terapia. Nos reservamos el derecho de hacer un cargo de \$30 cuota por falta a sus citas para aquellos pacientes que cancelen con menos de 24 horas de anticipación. Por favor tome nota que las compañías de seguros no cubrirán ni reembolsaran esta cuota, la cual será responsabilidad única del paciente. Aquellos pacientes que presenten un justificante medico para su inasistencia serán liberados de este cargo.

Firma: _____ Fecha: _____

NOTICE OF PRIVACY PRACTICES

To our patients, this notice describe how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our Commitment to your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if require by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information.

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

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2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including that may be used to make decisions about you, including medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Orthopaedic & Spine Surgery of Atlanta, attention Office Manager, 404-351-5812.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Orthopaedic & Spine Surgery of Atlanta, attention Office Manager, 404-351-5812.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Orthopaedic & Spine Surgery of Atlanta, attention Office Manager, 404-351-5812. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any question regarding this notice of our health information privacy policies, please contact Orthopaedic & Spine Surgery of Atlanta, attention Office Manager, 404-351-5812.

I hereby acknowledge that I have been presented with a copy of Orthopaedic & Spine Surgery of Atlanta's Notice of Privacy Practices.

Signature _____ Date _____

Name of Patient _____

INFORMATION YOU NEED TO KNOW

We kindly request you offer a **24 hour notice** for appointment changes. Because we do not “double book” appointments, which allow us to provide you more 1-on-1 care than most therapy locations, same day cancellations and no-shows waste appointment times that can be offered to other patients.

Patients who frequently fail to attend therapy appointments will be discharged from physical therapy and referred back to their physician for further action. **THERAPY** does **NOT** result in positive outcomes if attendance is sporadic.

We are required to notify employers when a patient covered by **Worker’s Compensation** benefits fails to attend a rehabilitation session. Repeated failure to attend therapy sessions may affect your Worker’s Compensation benefits and your standing with your employer.

Please make every effort to be timely to your scheduled appointments. Patients who show for a therapy appointment more than 15 minutes late may be asked to reschedule if it will have a negative impact on the patients who follow and those patient’s therapy program.

As a COURTESY to the patient, we are allowed by the building management to provide **ONE FREE parking token per week**. EFFECTIVE July 1, 2008, companies hired to transport Worker’s Compensation patients to/from visits are LIMITED to **ONE FREE token per patient per week**. To avoid having to pay for parking fees, Transportation Companies are encouraged to drop/pick up patients at the Downwood Circle parking deck entrance. We are unable to offer exceptions to this policy as this is dictated by the building management.

Communication is very important between the patient and our staff to insure a positive experience here at Spine Center Atlanta. Please never hesitate to communicate questions or concerns to the staff so we can better serve you and meet your rehabilitation needs.

WE WELCOME YOU TO SPINECENTERATLANTA: Rehabilitation, Aquatic and Wellness Center.
THANK YOU FOR ALLOWING US TO MEET YOUR REHABILITATION NEEDS.

Signature _____

Name (print) _____

Date _____

POOL ORIENTATION FOR REHAB PATIENTS

ORIENTATION PRIOR TO POOL THERAPY

1. Bring your own towel(s).
2. Lockers are available, but you are urged to store your valuables in the trunk of your vehicle or please leave them at home. You may change your clothes in the locker room area.
3. Clients may wear swimming suits under regular clothing to minimize changing time prior to pool exercise.
4. Clients are requested to shower PRIOR to entering the pool (to remove lotions, etc).
5. Clients are NOT allowed to participate in pool exercise for any of the following: open wound/cuts, skin infection, catheters, incontinence, infections (flu, GI infections, urinary tract/bladder infections and sore throats). Clients are to contact SPINE CENTER ATLANTA Rehabilitation, Aquatic and wellness center facility at 404 352 4200 if they are ill or have questionable areas of concern.
6. Clients must have shoes for pool area to prevent falls. Clients may use pool shoes in pool area. Suggested shoes include pool/surf shoes, rubber soled sandals, sneaker (not utilized for regular walking and not with black soles).
7. PHYSICAL THERAPY clients are NOT to enter the pool until the therapist is by poolside.

Signature: _____

Name: _____

Date: _____

Attendance Notice

Patients are encouraged to keep their scheduled appointments. Physical Therapy and Rehabilitation intervention is effective ONLY if patients take an active role in their care and recovery. This requires your regular attendance to therapy as prescribed by your physician and as recommended by your treating therapist/clinician.

We will gladly reschedule any visits on your behalf as long as we are provided with a 24-hour notice. This allows us the opportunity to offer open appointment slots to our other patients/clients.

To this end, please note Spine Center Atlanta's ATTENDANCE POLICY as outlined below.

- All patients covered under Worker's Compensation benefits are expected to attend ALL therapy sessions. Missed appointments require that we contact the Adjuster and/or Nurse Case Manager to report missed appointments. Missed appointments may affect your benefits under Worker's Compensation rules and regulations and may jeopardize your loss of approved therapy sessions. ANY PATIENT WHO MISSES 3 THERAPY SESSIONS WITHOUT A PHYSICIAN'S EXCUSE WILL BE DISCHARGED BACK TO THE PRESCRIBING PHYSICIAN DUE TO NON-COMPLIANCE. Please protect your Worker's Compensation benefits by planning ahead so you do not miss your scheduled visits.
- All patients covered by Private Insurance/Group Health Insurance benefits are expected to attend ALL therapy sessions. We reserve the right to charge a \$30.00 Missed Appointment Fee to those patients who cancel their appointments with less than a 24-hour notice. Please note insurance providers will not pay for nor reimburse for this fee, which will be the responsibility of the patient. Patients who provide the office with a physician's excuse will have this fee waived.

Patient Signature: _____

Date: _____

SpineCenterAtlanta

REHABILITATION, AQUATIC AND WELLNESS CENTER

AUTHORIZATION FOR TREATMENT, WARNINGS, RULES AND DECLARATIONS

WARNING!!

This is a Physical Therapy facility. Only patients referred by a practitioner of the healing arts are allowed. By signing this form, you certify that you are 18 years of age. When the facility operates in its business hours (8:00-6:00), only patients are allowed in the building. It is up to the patient to know the day-to-day times of operation. Unsupervised children are not allowed in the facility during the business hours. Children under the age of 14 are not allowed in the general exercise areas and must wait for their guardian in an approved space during operational hours. All members must receive approval, on their own, from a physician to participate in all actions associated with the Physical Therapy facility. This is not the responsibility of the center. By signing below, you acknowledge and relieve the facility, staff, owners, directors and affiliates of the responsibility for any injuries sustained while performing therapy activities in this facility.

BEWARE

You exercise and use the equipment at your own risk. There are dangerous cardio machines, selected machines with pulleys, gears, cables and belts that may cause injury. (You must get proper direction before using any machine, device or free weight in the facility). Understand that there are free weights on the premises and should you use them improperly, you are at risk of injury. Also, understand that extreme dangers may exist in the group therapy room. By taking any group therapy class, you may sustain injury or even death. (We advise you to pay attention to the equipment provided and used in these therapies.) You, as a patient, have the responsibility to double-check each piece of equipment, free weight, cardio machine, or piece of group fitness equipment for safety. In recognition of the possible dangers, transmission of body fluids, or even death connected with any physical activity, you hereby, knowingly and voluntarily waive any right of cause of action of any kind, whatsoever, arising as a result of any such activity, including group therapy class, from which any liability may or could accrue to the facility, employees, owners, directors, affiliates and therapists.

ALSO

Use of the changing rooms, showers, bathrooms and/or pool (follow the posted rules and regulations) may be dangerous and result in injury (i.e. falling, tripping or slipping on wet surfaces). You must understand the pool rules and assume full responsibility for your actions. Please read the rules in the swimming pool area. There are no lifeguards present. Ask a staff member for clarification if you do not clearly understand the rules.

FURTHER DETAILS

This is a business hours facility and at certain times, these premises are unmanned and can be dangerous. It is your responsibility to know these times. Injuries and death may occur. If you are in the facility during unmanned times, understand that you do so at your own risk and you must assume full responsibility and liability and hold the facility harmless during these unmanned times in this facility. Patients should never be in the therapy areas when a licensed clinician is not present.

By signing below, I accept and acknowledge the above rules, regulations, proclamations, and warnings. I further AGREE and CONSENT to allowing the clinical staff of Spine Center Atlanta to provide care to me, which may include physical examination and appropriate physical contact by me with one of more staff members during the course of each therapy session.

Signature of acceptance: _____

Print your name: _____

Date: _____

SpineCenterAtlanta
Rehabilitation, Aquatic and Wellness Center
3161 Howell Mill Rd NW Suite 410 • Atlanta, GA 30327
Tel 404.352.4200 • Fax 404.352.5200

WORK CONDITIONING PROGRAM GUIDELINES

Spine Center Atlanta is proud to offer a comprehensive Work Conditioning Program, available to patients with appropriate physician orders and with proper authorization through the patient's worker's compensation representative, either the Adjuster and/or Nurse Case Manager.

Definition. According to the United State Department of Labor and Industries, Work Conditioning is "an interdisciplinary, individualized, job specific program of activity with the goal of returning to work. Work Conditioning programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's tolerances. Work Conditioning Programs provide a transition between the acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular and psychosocial functioning of the worker".

Qualifications:

- The worker must have a valid order for Work Conditioning from a licensed practitioner of the healing arts.
- The worker must be covered under Worker's Compensation insurance and have the appropriate approval from the Adjuster and/or Nurse Case Manager to engage in such a program.
- The worker must have engaged in and successfully completed a routine of physical therapy which has adequately prepared the worker to engage in a Work Conditioning Program.
- The worker must be of adequate health such that the worker can engage in and tolerate a program of conditioning and work simulation between 2 and 4 hours, 3 to 5 days per week. The worker must have stable vital signs prior to entering the program AND at each visit.
- At any given time during the Work Conditioning program, the patient's resting heart rate may not exceed 75 beats per minute, the patient's target heart rate may not exceed 80% of that patient's calculated maximum heart rate (220 minus the patient's age) and the patient's diastolic blood pressure may not exceed a reading of "95".
- The worker must agree to engage in the Work Conditioning Program and have as one of their goals the return to gainful employment, even if a return to the previous/original job is not a realistic expectation of the patient and/or physician.

Patient Preparations:

- The patient is to wear loose and comfortable clothing to each Work Conditioning session. And the patient's attire should closely resemble the type of attire worn at work, although wearing one's "uniform" to each session is not necessary. Comfortable and safe shoes should be worn since conditioning/aerobic activities are utilized in this program.
- The patient should eat a healthy breakfast (if engaging in an AM Work Conditioning session. Or a healthy lunch (if engaging in a PM Work Conditioning session) This will avoid blood sugar level fluctuations during the program. The patient should hydrate adequately and also plan to drink water or replacement fluids during the work conditioning session.
- Please do not bring friends, family or visitors to a Work Conditioning Session. The Work Conditioning sessions are of greater length than a regular physical therapy session. Space constraints in the clinic and in the Reception Area make it difficult for the facility to accommodate visitors for several hours.
- It is important to be timely to Work Conditioning sessions. All 4 hour sessions begin promptly at 8:15am or 1:00 pm
- The patient is to assist the therapy staff in securing a current valid Job Description from the employer, Adjuster and/or Nurse Case Manager. If there is no Job Description it is important to notify the staff of such. Workers engaged in a Work Conditioning Program without a Job Description will be conditioned for a generic job category such as "laborer", "construction", "secretarial", "retail", etc., whichever category best fits the worker's job type.

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Program Parameters:

- The worker is scheduled for an initial evaluation session with the lead Work Conditioning therapist UNLESS the patient has already engaged in a physical therapy routine at this location/facility. In this case, the worker has already been evaluated, with a comprehensive history taken and a plan of care and goals in place.
- The Work Conditioning Program lasts 12 to 25 visits total, depending upon physician orders and worker's compensation approval. Programs are either 3 days/week or 5 days/week and last from 4 to 5 weeks.
- Work Conditioning Program sessions vary in length but generally begin at 1:1/2 to 2 hours and continue up to a maximum of 4 hours. The worker is progressed through the program, increasing duration, intensity, frequency and/or time (DIFT) each time the worker attends a session.
- The Work Conditioning Program does NOT include typical physical therapy modalities such as heat, ice, massage, ultrasound, electrical stimulation, aquatics, etc. Those modalities and/or treatments are reserved for patients engaged in acute or sub-acute physical therapy programs. The Work Conditioning client is expected to tolerate conditioning and work simulated activities without the use of pain-controlling or pain relieving therapies. Exceptions do apply and these are dependent upon physician orders and the worker's feedback as the program progresses.
- For those workers who find it necessary, this facility has, with approval of the insurance company, the ability to refer patient's vocational and/or psychological counseling services.
- The worker can expect mild to moderate soreness during the early stages of the Work Conditioning Program, which should improve dramatically during the program's progression
- A 24 hour notice is required for all appointment changes. Missed appointment are logged in the worker's chart and the Adjuster and/or Nurse Case Manager is notified of all missed appointments. The Work Conditioning Program is NOT successful if attendance is sporadic.

Program Conclusion:

- Once the Work Conditioning Program is concluded, the worker can expect one of the following to occur:
 - - The Worker will be returned to work with or without restrictions based upon physician input and employer cooperation.
 - The worker will be sent for an FCE (Functional Capacity Evaluation), an assessment conducted by a physical therapist which consists of a battery of physical "tests" to determine what the worker may/may not tolerate upon return to work, including classifying the worker's return-to-work category as "sedentary", "light", "medium", "heavy" or "very heavy".
 - The worker will receive an Impairment Rating from the ATP (Authorized Treating Physician).

No further physical therapy is indicated once the Work Conditioning Program is concluded, as the worker should have achieved Maximum Medical Improvement at the conclusion of the Work Conditioning Program. Moving forward, the worker must typically be out of therapy for at least 60-90 days before any further therapy is indicated OR the worker must experience an exacerbation of symptoms that would indicate the need for further therapy, requiring additional orders from the ATP and with worker's compensation agreement/approval.

PROGRAMA DE ACONDICIONAMIENTO PARA EL TRABAJO LINEAMIENTOS

El Spine Center Atlanta se enorgullece de ofrecer un programa completo de Acondicionamiento para el Trabajo, disponible para aquellos pacientes que cuentan con las ordenes medicas apropiadas y con la debida autorización del representante de Worker's Compensation, ya sea el ajustador a la enfermera a cargo del caso

Definition

De acuerdo con el Departamento del Trabajo e Industria de los Estados Unidos, este programa se define como un programa interdisciplinario, individualizado y diseñado en base a las descripciones de trabajo específicas de cada trabajador y tiene el objetivo de acondicionar al trabajador para su regreso a la actividad laboral. El programa de Acondicionamiento para el Trabajo utiliza tareas simuladas o reales y ejercicios para incrementar progresivamente la condición del paciente, basado en su tolerancia individual. Los programas de Acondicionamiento para el Trabajo proveen una transición entre el cuidado agudo y el regreso exitoso del trabajador a su labor y esta diseñado para mejorar las funciones biomecánicas, neuromusculares, cardiovasculares y psicológicas del trabajador

Qualifications:

- The worker must have a valid order for Work Conditioning from a licensed practitioner of the healing arts.
- The worker must be covered under Worker's Compensation insurance and have the appropriate approval from the Adjuster and/or Nurse Case Manager to engage in such a program.
- The worker must have engaged in and successfully completed a routine of physical therapy which has adequately prepared the worker to engage in a Work Conditioning Program.
- The worker must be of adequate health such that the worker can engage in and tolerate a program of conditioning and work simulation between 2 and 4 hours, 3 to 5 days per week. The worker must have stable vital signs prior to entering the program AND at each visit.
- At any given time during the Work Conditioning program, the patient's resting heart rate may not exceed 75 beats per minute, the patient's target heart rate may not exceed 80% of that patient's calculated maximum heart rate (220 minus the patient's age) and the patient's diastolic blood pressure may not exceed a reading of "95".
- The worker must agree to engage in the Work Conditioning Program and have as one of their goals the return to gainful employment, even if a return to the previous/original job is not a realistic expectation of the patient and/or physician.

Patient Preparations:

- The patient is to wear loose and comfortable clothing to each Work Conditioning session. And the patient's attire should closely resemble the type of attire worn at work, although wearing one's "uniform" to each session is not necessary. Comfortable and safe shoes should be worn since conditioning/aerobic activities are utilized in this program.
- The patient should eat a healthy breakfast (if engaging in an AM Work Conditioning session. Or a healthy lunch (if engaging in a PM Work Conditioning session) This will avoid blood sugar level fluctuations during the program. The patient should hydrate adequately and also plan to drink water or replacement fluids during the work conditioning session.
- Please do not bring friends, family or visitors to a Work Conditioning Session. The Work Conditioning sessions are of greater length than a regular physical therapy session. Space constraints in the clinic and in the Reception Area make it difficult for the facility to accommodate visitors for several hours.
- It is important to be timely to Work Conditioning sessions. All 4 hour sessions begin promptly at 8:15am or 1:00 pm

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- The patient is to assist the therapy staff in securing a current valid Job Description from the employer, Adjuster and/or Nurse Case Manager. If there is no Job Description it is important to notify the staff of such. Workers engaged in a Work Conditioning Program without a Job Description will be conditioned for a generic job category such as “laborer”, “construction”, “secretarial”, “retail”, etc., whichever category best fits the worker’s job type.

Program Parameters:

- The worker is scheduled for an initial evaluation session with the lead Work Conditioning therapist UNLESS the patient has already engaged in a physical therapy routine at this location/facility. In this case, the worker has already been evaluated, with a comprehensive history taken and a plan of care and goals in place.
- The Work Conditioning Program lasts 12 to 25 visits total, depending upon physician orders and worker’s compensation approval. Programs are either 3 days/week or 5 days/week and last from 4 to 5 weeks.
- Work Conditioning Program sessions vary in length but generally begin at 1:1/2 to 2 hours and continue up to a maximum of 4 hours. The worker is progressed through the program, increasing duration, intensity, frequency and/or time (DIFT) each time the worker attends a session.
- The Work Conditioning Program does NOT include typical physical therapy modalities such as heat, ice, massage, ultrasound, electrical stimulation, aquatics, etc. Those modalities and/or treatments are reserved for patients engaged in acute or sub-acute physical therapy programs. The Work Conditioning client is expected to tolerate conditioning and work simulated activities without the use of pain-controlling or pain relieving therapies. Exceptions do apply and these are dependent upon physician orders and the worker’s feedback as the program progresses.
- For those workers who find it necessary, this facility has, with approval of the insurance company, the ability to refer patient’s vocational and/or psychological counseling services.
- The worker can expect mild to moderate soreness during the early stages of the Work Conditioning Program, which should improve dramatically during the program’s progression
- A 24 hour notice is required for all appointment changes. Missed appointment are logged in the worker’s chart and the Adjuster and/or Nurse Case Manager is notified of all missed appointments. The Work Conditioning Program is NOT successful if attendance is sporadic.

Program Conclusion:

- Once the Work Conditioning Program is concluded, the worker can expect one of the following to occur:
 -
 - The Worker will be returned to work with or without restrictions based upon physician input and employer cooperation.
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 - The worker will receive an Impairment Rating from the ATP (Authorized Treating Physician).

No further physical therapy is indicated once the Work Conditioning Program is concluded, as the worker should have achieved Maximum Medical Improvement at the conclusion of the Work Conditioning Program. Moving forward, the worker must typically be out of therapy for at least 60-90 days before any further therapy is indicated OR the worker must experience an exacerbation of symptoms that would indicate the need for further therapy, requiring additional orders from the ATP and with worker’s compensation agreement/approval.

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