



SCHEDULING COMMUNICATION PREFERENCE

Please Print

PATIENT NAME: _____ **DATE OF BIRTH:** _____

In an effort to guard your privacy while allowing for efficient scheduling, please answer the following questions on how best to contact you regarding scheduling issues.

- No, it is not ok to leave messages or voicemails.
- Yes, it is ok to leave messages or voicemails.

Please write all of YOUR contact numbers where we may leave a message:

Home Phone: _____ Work Phone: _____ Cell Phone: _____
 (_____) _____ (_____) _____ (_____) _____

Persons authorized to receive messages/information at above numbers

Name	Relationship	Name	Relationship
------	--------------	------	--------------

Only the above people will be able to confirm or change your appointment.

Please note: ANY PERSON (including family members) requesting **ANY** information, including appointment confirmations and changes, **MUST** provide us with 3 points of information about you including: 1. Name, 2. Date of Birth, 3. Zip Code.

Thank you for assisting us.

I authorize John Muir Therapy Center to leave protected health information inquiries that may include the following: Name of patient; Name and phone number of our clinic; Name of treating Therapist(s) or Doctor; Name of referring Doctor; Appointment times and dates; and Scheduling information/requests.

Signature: _____ Date: _____

Relationship, if not patient: _____

1. Preferred language for discussing healthcare with your provider: _____

2. Do you consider yourself of Hispanic or Latino Ethnicity? **Yes** **No**

3. Which category best describes your race? Circle One

Asian Black/African-American/African Pacific Islander or Native Hawaiian

Caucasian Native American/American Indian/Eskimo Multi-racial/Bi-racial Other



CANCELLATION/NO SHOW/CO-PAY POLICIES

Thank you for choosing John Muir Health for your therapy services. Due to the volume of new patients and limited appointments, we require that you notify our office **24 hours in advance** if you are unable to keep your appointment. We do understand that emergencies arise. In such cases, please contact us as soon as possible to cancel or reschedule your appointment.

Failure to call and cancel an appointment is considered a "No Show." **After two such occurrences, any additional scheduled appointments will automatically be cancelled.** Your therapist will consider you a discharged patient, and will send a note to your physician indicating non-attendance. You will have to contact your therapist to discuss continuation of therapy.

Along with quality treatment, it is the goal of this clinic to treat patients at their scheduled time. If you are more than ten minutes late for your appointment, your appointment may need to be rescheduled.

Co-pays are collected prior to each treatment. Failure to pay may result in a bill from the health system's billing department.

We want to meet the goals of all of our patients and appreciate your assistance. Thank you for your help! Please let us know if there is something more we can do for you.

To cancel or reschedule appointments, please call (925) 947-5300.

Sid Hsu, Director
Rehabilitation Services
John Muir Health

I acknowledge that I have read and understand these policies.

Patient Signature

Date



CONDITIONS OF REGISTRATION

Consent to Medical and Surgical Procedures: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or Facility services rendered the patient under the general and special instructions of the patient's physician or surgeon.

Personal Valuables: The Facility shall not be liable for loss or damage to personal property.

Trainees: The Facility conducts training programs for health care professionals. These persons may be observing or participating in the Facility's treatment program. They will be under the direct supervision of licensed professionals. The undersigned has a right to refuse to have trainees participate, at any time, in his/her care.

Consent to Photography: The undersigned consents to photography (still images, videotaping, filming, etc.) for purposes related to diagnosis and treatment or for use in training or education programs.

Release of Information upon Public Inquiry: Requests for patient information must contain the patient's name. The Facility may then, unless otherwise requested by the patient, legal representative, or provider of health care, release at its discretion the patient's condition described in general terms (that do not communicate specific medical information) and the patient's location within the hospital. The Facility will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the Facility is permitted or required by law to release information. No information will be released to the public with regards to psychiatric and/or chemical dependency treatment.

Release of Information for Payment: To the extent necessary to obtain payment, the Facility may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the Facility's charges, including, but not limited to, insurance companies, Health Care Service Plans, workers' compensation carriers, social security administration and peer review organizations. Special permission is needed to release this information if the patient is treated for alcohol or drug abuse.

Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Facility in accordance with the regular rates and terms of the Facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Assignment of Insurance Benefits: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the Facility of any insurance benefits otherwise payable to the undersigned for services rendered at a rate not to exceed the Facility's usual and customary charges. It is agreed that payment to the Facility, pursuant to this authorization, by an insurance company/Health Care Service Plan shall discharge said insurance company/Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Health Care Service Plans: It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services at the Facility. The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible, co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health Care Service Plan at the Facility. For non-emergency services, it is the patient's responsibility to ensure his/her Plan has authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergent services will be considered a denial for a non-covered benefit, and payable by the undersigned.

The undersigned acknowledges he/she has read and understands the Conditions of Registration and has received a copy thereof. Furthermore, the undersigned is the patient, the patient's legal representative or is duly authorized as the patient's general agent to execute the above and accept its terms.

PRINT NAME: PATIENT, LEGAL REPRESENTATIVE, AGENT SIGNATURE DATE OF BIRTH DATE/TIME
RELATIONSHIP IF NOT PATIENT WITNESS [] Unable to sign

Acknowledgement of the Notice of Privacy Practice The undersigned acknowledges he/she has received a Copy of the Notice of Privacy Practices.

If no signature of acknowledgement received, describe the good faith efforts to obtain and give reason not obtained.

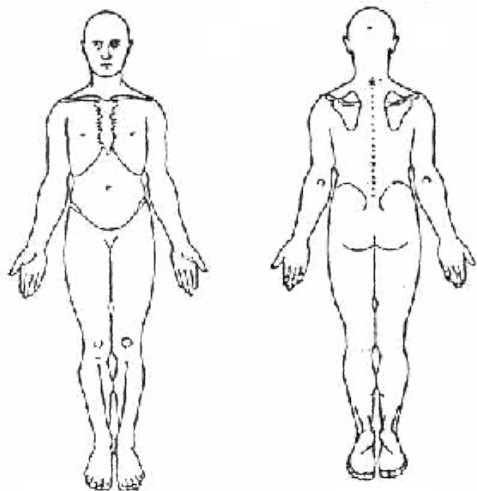
DATE TIME SIGNATURE: PATIENT, LEGAL REPRESENTATIVE, AGENT DATE TIME STAFF SIGNATURE

Outpatient Rehabilitation Services
Medical History/Subjective Information

Patient Name: _____ Date: _____ Date of Birth: _____
 Occupation: _____ Weight: _____ Do you smoke: Yes No
 Circle: Right handed Left handed Do you feel safe in your home/living environment? Yes No
 Upon discharge from therapy, your home/living environment will be:
 Private home/apt ___ Assisted living ___ Board and care ___ Other _____
 Is there anyone in your home/living environment available to assist you with home care? Yes No
 Do you have any cultural, language or other special needs we should be aware of? Yes No
 If yes, please specify: _____

Where is your injury/condition located? _____ Date of injury: _____
 (Indicate each injury on body chart below)

R **L** **L** **R** Your main symptom: Pain ___ Numbness ___ Tingling ___
 Other: _____



How did your injury/condition occur? _____

Is your pain:
 Getting better ___ Getting worse ___ Staying same ___

Circle your range of pain (0 = no pain, 10 = the most pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

What improves your pain/symptoms? _____

What functions/activities make your symptoms worse? _____

What are your goals for treatment? _____

***Any significant other Diagnoses or Conditions?** Tuberculosis(TB): Yes No
 Arthritis: Yes No If Yes, Date: _____ Cancer: Yes No
 Diabetes: Yes No Heart Condition: Yes No ; Hypertension: Yes No
 Hepatitis: Yes No Osteoporosis: Yes No
 Seizure: Yes No Stroke: Yes No If Yes, Date: _____
 Unexplained weight loss? Yes No Other: _____

***Any Allergies (medication or otherwise):** _____

***List all medications that you are currently taking (include Over-the-Counter /herbal/ and any medications you anticipate needing to self-administer while onsite for therapy?):** _____

***Past significant Operations/Surgeries:** _____

List any diagnostic tests that you have had for this condition: X-Ray: Yes No MRI: Yes No
 Other: _____

Have you been treated before or elsewhere for this injury/condition? If yes, please specify: _____

Form Completed By (if not by patient): _____

Reviewed By: _____

(Therapist's Signature)

FUNCTIONAL QUESTIONNAIRE

Please circle tasks that have been most affected by your injury/condition. Please circle the number that best indicate how much the tasks has been affected.				
1 = Can do with no difficulty		2 = Can do with some difficulty		
3 = Can do with great difficulty		4 = Can not do at all		
Sitting	1	2	3	4
Standing	1	2	3	4
Walking	1	2	3	4
Up & down stairs	1	2	3	4
Sleeping	1	2	3	4
Getting up or down from bed / chair	1	2	3	4
Driving	1	2	3	4
Bathing / Grooming	1	2	3	4
Daily job activities / work tasks	1	2	3	4
Housework / Yard work	1	2	3	4
Laundry	1	2	3	4
Vacuuming	1	2	3	4
Putting on socks / shoes	1	2	3	4
Groceries	1	2	3	4
Sports / Recreation	1	2	3	4
Lifting	1	2	3	4
Carrying	1	2	3	4
Pushing / Pulling	1	2	3	4
Reaching overhead	1	2	3	4
Reaching behind (for wallet, and/or fasten bra)	1	2	3	4
Dressing	1	2	3	4
Gripping / Squeezing	1	2	3	4
Writing	1	2	3	4
Other _____	1	2	3	4
Other _____	1	2	3	4
Additional Comments:				

PATIENT NAME: _____