

Outpatient Pediatric Physical Therapy

Medical History/ Subjective Information

Patient's Name: _____ Date: _____ Date of Birth _____

Do you have any cultural, language or other special need we should be aware of? Yes No

If yes, please specify: _____

Where is your injury/condition located (if applicable)? _____ Date of injury: _____

Is your pain (if applicable)?:

Getting better _____ Getting worse _____ Staying the 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

Current Health Status: Excellent _____ Very Good _____ Fair _____ Poor _____ Other _____

*Any significant other Diagnoses or Conditions?

Arthritis: Yes No If Yes, Date: _____

Tuberculosis (TB) Yes No

Diabetes: Yes No

Cancer: Yes No

Hepatitis: Yes No

Heart Condition Yes No

Seizure: Yes No

Osteoporosis: Yes No

Unexplained weight loss? Yes No

Stroke: Yes No If Yes, Date: _____

Other: _____

*Any Allergies (medication or otherwise): _____

*List all medications that you are currently taking (include over-the-counter medications/herbal):

_____*Past significant Operations/Surgeries:

Reviewed Therapist Signature: _____ Date: _____



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



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
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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

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.

DATE

TIME

SIGNATURE: PATIENT, LEGAL REPRESENTATIVE, AGENT



Dear Parent/Guardian:

Thank you for choosing John Muir Health for your therapy services.

We strive to provide the best care to each patient and appreciate your assistance.

We ask that you remain on the premises to allow for discussion of your child's care/treatment or should there be any type of emergency.

We understand siblings may need to accompany you to your child's appointment(s). In such circumstances please monitor the safety of all siblings while on the premises and for safety reasons please do not allow them to use any therapeutic equipment or toys.

Thank you,

Sid Hsu, Director
John Muir Health
Rehabilitation Services

I acknowledge and understand the need to be present during my child's appointment. John Muir Health will not be held liable for my child's welfare in the absence of a parent/guardian and may contact emergency services as necessary to safeguard my child. I accept responsibility for monitoring the behavior and safety of siblings that may attend therapy sessions. John Muir Health will not be held liable for any injury a sibling may incur due to lack of parental supervision.

Parent/Guardian Print Name: _____

Signature: _____ Date: _____

Relation to patient: _____