



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 |



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

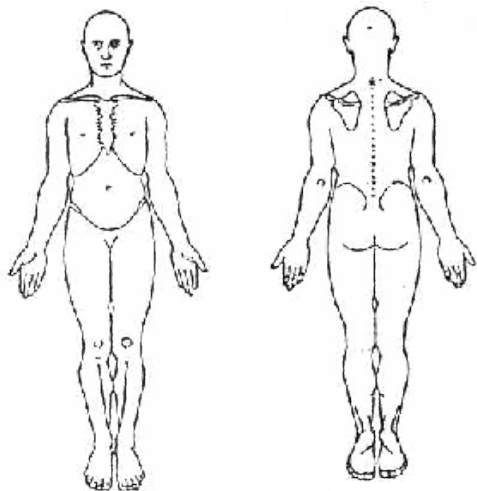
DATE TIME STAFF SIGNATURE

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)

*Summary List Components – Joint Commission Standard RC.02.



OPTIMAL INSTRUMENT Demographic Information

1. Date of Birth _____
mm / dd / yyyy
2. Sex
 - 1) ___ Male
 - 2) ___ Female
3. Race
 - 1) ___ Aleut/Eskimo
 - 2) ___ American Indian
 - 3) ___ Asian/Pacific Islander
 - 4) ___ Black
 - 5) ___ White
 - 6) ___ Other
4. Ethnicity
 - 1) ___ Hispanic or Latino
 - 2) ___ Not Hispanic or Latino
5. Insurance (Please check all that apply)
 - 1) ___ Workers' compensation
 - 2) ___ Self-pay
 - 3) ___ HMO/PPO/private insurance
 - 4) ___ Medicare
 - 5) ___ Medicaid
 - 6) ___ Auto
 - 7) ___ Other
6. Education (Please check one)
 - 1) ___ Less than high school
 - 2) ___ Some high school
 - 3) ___ High school graduate
 - 4) ___ Attended or graduated from technical school
 - 5) ___ Attended college, did not graduate
 - 6) ___ College graduate
 - 7) ___ Completed graduate school/advanced degree
7. Please check the combined annual income of everyone in your house:
 - 1) ___ Less than \$10,000
 - 2) ___ \$10,000–\$14,999
 - 3) ___ \$15,000–\$24,999
 - 4) ___ \$25,000–\$34,999
 - 5) ___ \$35,000–\$49,999
 - 6) ___ \$50,000–\$74,999
 - 7) ___ \$75,000–\$99,999
 - 8) ___ \$100,000–\$149,999
 - 9) ___ \$150,000 or more
8. Employment/Work (Check all that apply)
 - 1) ___ Working full-time outside of home
 - 2) ___ Working part-time outside of home
 - 3) ___ Working full-time from home
 - 4) ___ Working part-time from home
 - 5) ___ Working with modification in job because of current illness/injury
 - 6) ___ Not working because of current illness/injury
 - 7) ___ Homemaker
 - 8) ___ Student
 - 9) ___ Retired
 - 10) ___ UnemployedOccupation: _____
9. Do you use a: (Check all that apply)
 - 1) ___ Cane?
 - 2) ___ Walker, rolling walker, or rollator?
 - 3) ___ Manual wheelchair?
 - 4) ___ Motorized wheelchair?
 - 5) ___ Other: _____
10. With whom do you live? (Check all that apply)
 - 1) ___ Alone
 - 2) ___ Spouse/significant other
 - 3) ___ Child/children
 - 4) ___ Other relative(s)
 - 5) ___ Group setting
 - 6) ___ Personal care attendant
 - 7) ___ Other: _____
11. Where do you live?
 - 1) ___ Private home
 - 2) ___ Private apartment
 - 3) ___ Rented room
 - 4) ___ Board and care/assisted living/group home
 - 5) ___ Homeless (with or without shelter)
 - 6) ___ Long-term care facility (nursing home)
 - 7) ___ Hospice
 - 8) ___ Other

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 13 2. 8 3. 14)

1. ____ 2. ____ 3. ____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs* without any difficulty, you would choose: Primary goal. 13)

Primary goal. ____

Confidence–Baseline

Instructions: Please circle the level of confidence you have for doing each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

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Adapted/revised in July 2005, August 2006, and December 2012 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515-530.