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.

Please let us know if your child has any special needs requiring additional attention.

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.

Parent/Guardian Print Name: _____

Signature: _____ Date: _____

Relation to patient: _____

JOHN MUIR HEALTH

Outpatient Pediatric Rehabilitation Services

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:_____

JOHN MUIR HEALTH

Patient Name:
DOB:

PEDIATRIC HISTORY FOR OCCUPATIONAL THERAPY EVALUATION

Please complete this form if your child is being seen for pediatric occupational therapy.

MEDICAL HISTORY

In order to provide a comprehensive evaluation of your child, we request that you take a few minutes to fill in the following questionnaire as accurately as possible.

Please list both current and past professionals involved with your child:

Pediatrician: _____ Dentist: _____

Ophthalmologist: _____ Cardiologist: _____

Neurologist: _____ Orthopedist: _____

Other Specialist(s):_____

Speech Therapist(s):_____

Previous Occupational/Physical Therapist(s):_____

Has your child ever had surgery? Yes_____ No _____

Has your child ever been admitted to the hospital? Yes _____ No _____

What would you like to gain from this evaluation? Please be as specific as possible:

_____

_____

_____

JOHN MUIR HEALTH

Patient Name:
DOB:

FAMILY HISTORY

Are there any family stories of others with similar difficulties? Yes _____ No _____

_____

_____

_____

Has a sibling had similar problems? Yes _____ No _____

Does either parent feel that "I was just like this", so why worry? Yes _____ No ____

YOUR THOUGHTS

1. Are there any ways in which you would like to be able to interact differently with your child? Yes ____ No ____. If yes, what are they?

   _____

   _____

   _____

2. What do you consider to be the two or three most important issues associated with your child's difficulty?

   _____

   _____

   _____

3. Is there anything else you feel we should know about your child?

   _____

   _____

   _____

JOHN MUIR HEALTH

Patient Name:
DOB:

Your answer to the following questions will be very helpful as they enable us to understand your concerns about your child's development and how his or her difficulties may be affecting his or her life now. Please feel free to add any remarks that would help clarify your answers.

DEVELOPMENTAL HISTORY

	Approximate Age	Remarks
1. ***At what age did your child**:*		
a. sit alone?		
b. crawl?		
c. walk without holding on?		
d. button small buttons independently?		
e. tie shoes (bow)?		
f. ride a tricycle?		
g. ride a bicycle without training wheels?		
h. pump self on swing?		
i. speak first word?		
j. speak sentences?		

	Yes	No	Remarks
2. ***Do you know or do you sometimes suspect that your child has a vision problem?***			
a. is that problem unable to be corrected with glasses?			
b. do you feel that your child bumps into things or has poor coordination because he/she does not see things the way other children do?			
3. ***Do you know or do you sometimes suspect that your child has a hearing problem?***			
a. has your child been identified as having a hearing loss?			
b. does he or she have a history of chronic middle or inner ear infections?			
c. do you sometimes feel that your child doesn't listen, hear, or understand you when you talk to him or her?			

JOHN MUIR HEALTH

Patient Name:
DOB:

	Yes	No	Remarks
4. ***Has your child been identified as having cerebral palsy, mental retardation, or any other developmental disorders?*** If yes, please specify_____			
5. ***Are you or is anyone else concerned that your child might have a motor delay?***			
6. ***Are you or is someone else concerned that your child might have a cognitive delay?***			
7. ***Do you think that your child is brighter than he or she demonstrates to others?***			
8. ***Was your child premature?***			

	Yes	No	Sometimes	Remarks
9. ***When your child was an infant:***				
a. was it difficult to engage your baby in peek-a-boo, pat-a-cake, or other interactive games?				
b. did your baby seem to play poorly with toys or other objects (e.g., busy boxes, pots and pans)?				
c. was your baby more fussy or irritable than most babies?				
e. did your baby seem more floppy than other babies?				
f. was it hard to get your baby to go to sleep or did you baby seem to sleep less than other babies?				
g. did you baby have trouble sucking?				
h. did you baby dislike food of certain textures?				
i. did you baby seem to dislike playing while lying on his or her stomach (e.g., did he/she prefer an infant seat, walker, or swing to being on the floor or in a playpen)?				

JOHN MUIR HEALTH

Patient Name:
DOB:

	Yes	No	Sometimes	Remarks
10. ***Now, compared to other children your child's age, does your child seem to:***				
a. be overly active?				
b. be not active enough?				
c. frequently, and seemingly unknowingly, put him- or herself in potentially dangerous situations?				
d. be too cautious or fearful?				
e. hit or fight more often than other children?				
f. be easily distracted or have difficulty paying attention?				
g. have trouble looking at objects with which he or she is playing?				
h. have excessive difficulty finding one particular object from among others (e.g., matching socks, finding toy on shelf, finding paper in desk)?				
i. have excessive difficulty learning new skills (e.g., writing, catching a ball, riding a bike)?				

SENSORY PROCESSING

AUDITORY	Yes	No	Sometimes	Remarks
1. ***Compared to other children his or her age, does your child seem to:***				
a. overreact to unexpected or loud noises?				
b. under react to loud noises?				
c. seem to really like loud noises?				
d. have difficulty paying attention when there are other noises nearby?				
e. take excessive time to respond when spoken to?				
f. need frequent repetition of instruction?				

JOHN MUIR HEALTH

Patient Name:
DOB:

	Yes	No	Sometimes	Remarks
OLFACTORY				
2. ***Compared to other children his or her age, does your child seem to:***				
a. overreact to certain smells?				
b. under react to smells that others find noxious?				
VISUAL				
3. ***Compared to other children his or her age, does your child seem to:***				
a. over-rely on vision (e.g., resist having his/her eyes covered)?				
b. notice little things that others don't see?				
c. be easily distracted by visual stimuli?				
TACTILE				
4. ***Compared to other children his or her age, does your child seem to:***	Yes	No	Sometimes	Remarks
a. avoid playing with "messy" things (e.g., finger paint, paste, mud, sand)?				
b. <u>really</u> dislike having his or her face washed or wiped?				
c. be irritated by clothing of certain textures?				
d. prefer to go without clothes now or as a toddler?				
e. prefer wearing pants or sleeves, even in mild weather?				
f. keep his/her jacket on even when others have removed theirs?				
g. dislike foods of certain textures?				
h. object to being touched if he/she does not initiate (particularly if the touch is unexpected)?				
i. pinch, bite or otherwise hurt himself/herself on purpose?				

JOHN MUIR HEALTH

Patient Name:
DOB:

	Yes	No	Sometimes	Remarks
j. isolate himself/herself from other children, preferring to play alone?				
k. frequently hit or push other children?				
l. tend to clutter work areas excessively?				
m. have excessive difficulty switching from active to quiet activities (e.g., playground to seatwork)?				
n. have an unusually high tolerance for pain?				
o. overreact to minor injuries or touch?				
p. dislike having his or her hair combed, brushed, or styled?				
q. dislike having his or her teeth brushed?				
VESTIBULAR-PROPRIOCEPTIVE	Yes	No	Sometimes	Remarks
5. ***Compared to other children his or her age, does your child seem to****:*				
a. dislike or fear roughhousing or being tossed in the air by adults?				
b. have poor balance?				
c. be excessively fearful of things that move fast (e.g., playground equipment, carnival rides)?				
d. get car sick during short trips?				
e. ride longer or harder on certain playground equipment (e.g., swing, merry-go-round)?				
f. <u>really</u> enjoy activities that involve jumping, crashing into things, and falling?				

JOHN MUIR HEALTH

Patient Name:
DOB:

MOTOR, SOCIAL, AND SCHOOL SKILLS

MOTOR SKILL	Yes	No	Sometimes	Remarks
1. ***Compared to other children of the same age and sex, does your child seem to have difficulty:***				
a. manipulating small objects (e.g., buttons, knobs on toys)?				
b. using pencils, crayons, scissors, paintbrushes?				
c. catching a ball?				
d. throwing a ball?				
e. riding a tricycle (if over age 6)?				
2. ***Compared to other children of the same age and sex, does your child more often seem to:***				
a. engage in sedentary activities (e.g., watching TV)?				
b. prefer fine motor activities (e.g., coloring, building with blocks)?				
c. prefer gross motor activities (e.g., swinging, running)?				
d. trip over or bump into things?				
SOCIAL ADJUSTMENT				
3. ***Compared to other children of the same age, does your child:***				
a. find it hard to make friends among peers?				
b. prefer the company of adults to that of peers?				
c. prefer to play with younger children rather than peers?				
d. prefer to play alone?				
e. frequently get discouraged easily, or express feelings of failure or frustration?				
f. seem to have less fun when playing?				

JOHN MUIR HEALTH

Patient Name:
DOB:

	Yes	No	Sometimes	Remarks
g. frequently express feelings of anger or frustration by hitting or kicking rather than with words?				
h. frequently throw temper tantrums?				
SCHOOL PERFORMANCE				
4. ***Compared to other children of the same age, does your child:***				
a. have poor handwriting?				
b. make reversals of letters or numbers when writing or copying (if older than age 7)?				
c. perform the same task with either hand (e.g., writing, eating)?				
d. seem to tire quickly, have poor posture, or need to prop his or her head while reading or writing at a desk?				
e. find gym class or sports to be a particularly difficult or frustrating experience?				
f. tend to clutter work areas excessively?				
g. have excessive difficulty switching from active to quiet work (e.g., playground to seatwork)?				

JOHN MUIR HEALTH

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

JOHN MUIR HEALTH

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 tha the/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, its 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**

_____ _____ ☐ **Unable to sign**
RELATIONSHIP IF NOT PATIENT **WITNESS**

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

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

_____

_____
DATE **TIME** **STAFF SIGNATURE**

JOHN MUIR HEALTH

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