Physical Therapy & Rehabilitation Department

Dear MOS patient,

The physicians at Muir Orthopedic Specialists are owners of the physical therapy and rehabilitation departments at: 2405 Shadelands (Walnut Creek), 5201 Norris Canyon Rd #300 (San Ramon) and 350 John Muir Parkway (Brentwood). The medical group has individually selected and trained the staff in this department. Clinicians who are employed by MOS typically spend a half day a month observing surgery and participate in monthly physician lectures. These are some of the educational and training tools MOS uses to enhance patient care and develop strong communication between patients, physicians, and rehabilitation staff.

However, the MOS physicians realize that this community offers several therapy locations and you are under no obligation to have your rehabilitation take place at our facility. Furthermore, if you feel the distance you have to travel to attend appointments at any of our locations is too great, we would be happy to provide you with a list closer to your home or work.

Sincerely,

Dr. Miranda
President of Muir Orthopedic Specialists

________ I understand the above statement and would like to receive treatment at this facility.

________ I understand the above statement and would like to receive treatment at a different facility.

__________________________________
Patient signature

Leading Edge Care, Old Fashioned Caring

Mailing Address P.O. Box 31396 – Walnut Creek, CA 94598
CONFIDENTIAL COMMUNICATIONS PREFERENCE

Please select all that applies to your needs. Date and sign below.

PROTECTED HEALTH INFORMATION

Please see checked boxes below for authorization of release of PHI: (i.e. surgery type, date, location, Diagnostic type, date, location, etc.)

☐ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN CALL.

☐ Y ☐ N Leave results/PHI on answering machine and/or voice mail.
☐ Y ☐ N Number(s) authorized to leave messages regarding PHI.

1. (____)________________________
2. (____)________________________
3. (____)________________________

Addresses to mail PHI information to:
________________________________________________________________________
________________________________________________________________________

Persons authorized to receive PHI

__________________________________________    _______________________  
Name           Phone    Relationship

__________________________________________    _______________________  
Name           Phone    Relationship

Billing statements and correspondence:

Any correspondence related to your health information will be automatically mailed to your home address unless indicated otherwise. Do you agree to this? ☐ Yes  ☐ No

If No, please provide alternative address:

________________________________________________________________________
Address    City   State  Zip Code

I _______________________ acknowledge in signing this document, then I am giving Muir Orthopedic Specialists permission to release PHI (Private Health Information) to specified people and places listed above.

__________________________________________    _______________________  
Parent/Guardian Signature    Date
Patient Medical History and Health Risk Profile

Patient Name: ______________________________________________________ Date: ____________

Age: _________________   Height: ____________   Weight: ____________________________ Gender: Male (     ) Female (     )

Emergency contact:

Name: ___________________________________________________ Phone:  _________________________________________________

Relationship: ______________________________________________

1) Problems to be treated today: ________________________________________________________________________________

Have you had treatment for this problem before?   (     ) Yes       (      ) No  When:____________________________

Please describe the type of treatment: ________________________________________________________________________

Have you had surgery associated with this problem?   (      ) Yes      (      ) No
If so, please list date and type: ____________________________________________________________________________

2) Do you have any other condition that is aggravated by exercise? ______________________________________________

3) Please list the names of any primary care physician / internist / cardiologist that you are seeing, or have seen in the past:

Name: ______________________________________________    Name: _________________________________________________

Phone: ______________________________________________    Phone: _______________________________________________

4) Are you currently pregnant? (  ) Yes (  ) No

5) Do you need assistance with any of the following?:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping/Errands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic chores</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6) Has your illness / disability caused any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Emotional Problems             |     |    |

7) Do you have or have you had any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel faint or dizzy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent pain in heart or chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacemaker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous disorders</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Allergies                    |     |    |

| Seizures                     |     |    |

| Balance problems             |     |    |

| Hearing Problems             |     |    |

| High cholesterol             |     |    |
| Cancer                       |     |    |

| Tubercolosis                 |     |    |

8) Please circle the closest answer or leave item blank if you do not know:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>1-5</th>
<th>10-20</th>
<th>30-40</th>
<th>&gt;50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes (per day)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholic drinks (per week)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Fitness (per week)</td>
<td>None</td>
<td>Occasional/Recreational</td>
<td>3+ days/week for at least 15 min.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9) Respiratory Status:  Normal   Moderate   Severe (shortness of breath with mild exertion)

For office use only:  I have reviewed the Health Risk Profile and the following is appropriate:

- Contact MD with CV Screening Request Form or request results of exercise test within last 2 years;
- Further cardiovascular screening is not necessary at this time.

Clinician Signature: _____________________________
WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations.

<table>
<thead>
<tr>
<th>ACHE</th>
<th>NUMBINES</th>
<th>SPINS &amp; NEEDLES</th>
<th>BURNING</th>
<th>STABBING</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>OOO</td>
<td>---</td>
<td>XXX</td>
<td>///</td>
</tr>
<tr>
<td>AAA</td>
<td>OOO</td>
<td>---</td>
<td>XXX</td>
<td>///</td>
</tr>
<tr>
<td>AAA</td>
<td>OOO</td>
<td>---</td>
<td>XXX</td>
<td>///</td>
</tr>
</tbody>
</table>

PLEASE MARK ON THE LINE WITH AN X THE DEGREE OF PAIN NOW

NO PAIN                         WORST PAIN

ARE YOU NOW: BETTER_____ WORSE_____ SAME_____ SINCE THE PROCEDURE

Name: _______________________________________________________ Date: ________________
AUTHORIZATION FOR OUTPATIENT TREATMENT

I have been informed of the treatment considered necessary and that the treatment and procedures will be performed by physical therapists, occupational therapists, chiropractors, athletic trainers, physical therapy assistants, and exercise physiologists employed by Muir Orthopaedic Specialists. Authorization is hereby granted for such treatment and procedures.

I certify that the information given by me is correct and accept full responsibility for all charges. I hereby assign and authorize payment directly to the above named clinic of all insurance benefits. If my current policy prohibits direct payment to Muir Orthopaedic Specialists, I hereby instruct and direct Muir Orthopaedic Specialists to bill me directly for the insurance payments made to me. I understand that I am responsible for any balance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court costs, attorney's fees and/or collection agency commissions or charges.

MEDICAL RECORDS AUTHORIZATION
Muir Orthopaedic Specialists is hereby authorized to release information pertinent to my treatment to any doctor, insurer, compensation carrier, attorney or welfare agency involved with my case.

MEDICARE PATIENTS
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

I authorize the treating clinician to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as an original.

_______________________________________________   ____________________________       ______________
Patient Signature  Witness  Date

As parent or guardian, I have read, understand, and agree with all items stated above and hereby authorized by MOS to administer physical medicine treatment as prescribed to _________________________________.

_______________________________________________   ____________________________       ______________
Parent/Guardian Signature  Parent/Guardian Name  Date