MUIR ORTHOPAEDIC SPECIALISTS

SPECIALIZED • INNOVATIVE • COMPASSIONATE

At Muir Orthopaedic Specialists (MOS), our mission is to develop a comprehensive practice in which we provide quality orthopedic care in a professional manner. We strive to treat all our patients as we would our family members, with respect, empathy and concern for their well-being.
We understand that today we live in a fast-paced world, and the respect of your time is of great importance to us. As we prepare for your upcoming visit, we kindly ask that you prepare the following items and bring them in completed at the time of your visit:

- ✓ **Completed patient forms (Health History, Medication Form, Acknowledgment of Privacy Practices, and Financial Policy)**. Having these forms completed will help speed up your check in process and provide the medical staff the information they will need for your visit.

- ✓ **Photo ID (driver's license, passport, etc.)** It is of great importance that we protect our patient's medical and private information.

- ✓ **Current Insurance card(s).** Bringing these cards to your visit will help us receive all accurate insurance information for billing purposes. If you do not have insurance and are paying out of pocket, and we have not reviewed the cash pay policy with you, please contact our accounting department at (925) 210-8593.

- ✓ **Your co-pay or co-insurance as indicated by your insurance policy**. If you are unsure of your copay or co-insurance, please call your insurance carrier prior to coming in.

- ✓ **Recent EMG or Nerve Conduction Study Results.** If applicable.

- ✓ **CD of your most recent imaging (CT, MRI & X-Ray), if done at a non-John Muir facility.** This is extremely important to bring to your visit. Your provider strives to give you high quality care and to do so, these images are essential.
  "*Simply put, pictures are worth a thousand words and we cannot rely on radiologist's reports for our orthopedic eyes*"

Thank you for choosing Muir Orthopaedic Specialists for your medical needs. We look forward to meeting you and providing you excellent care. If you have any questions regarding your upcoming visit, please reach out to us by calling (925) 939-8585. You can also communicate with us by signing up for our Patient Portal at www.muirortho.com/portal.

P 925.939.8585 • F 925.933.4932 • www.muirortho.com
Office Locations: Brentwood • Concord • San Ramon • Walnut Creek
Mailing Address: PO Box 31396 • Walnut Creek, CA 94598

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HEALTH HISTORY

Please complete the following information for review by your provider.

Name: _____ Birth Date: ____/____/____ Age: _____

Height: _____ Weight: _____ Sex: O M O F Dominant Hand: O Right O Left

Referring Provider: _____ Occupation: _____

Patient Medical History (mark all that apply)

__Acid Reflux	__Depression	__Hepatitis	__Osteoporosis	__Anemia
__AIDS/HIV	__Diabetes	__High Blood Pressure	__Sleep Apnea	__Enlarged Prostate
__Arthritis	__Drug Abuse	__Irregular Heart Beat	__Liver Disease	__Heart Disease
__Bleeding Disorder	__DVT (Blood Clot)	__Kidney Disease	__Thyroid Disease	__Other:
__Cancer	__Fibromyalgia	__Lung Disease	__Heart Attack	_____
Type & Year_____	__Gout	__COPD	__Stroke	_____
_____	__Atrial Fibrillation	__Seizure Disorder	__Asthma	

Previous Surgeries & Date(s): ☐ ***NONE***

1.	4.
2.	5.
3.	6.

Is Injury Work Related ? __Yes __No **If yes, have you filed a work comp claim?** __Yes __No

Family Medical History (Mark if your immediate family members (mom, dad, siblings) have any of these conditions)

__Alcoholism __Bleeding __Diabetes __Heart Disease __Kidney Disease __Seizures

__Arthritis __Cancer __Gout __High Blood Pressure __Mental Illness __Stroke

Social History

Do you exercise regularly? __Yes __No Describe: _____

Tobacco Use? __Yes __No Type: _____ Amount per day _____ # of years used: ____

Alcohol Consumption? __Yes __No If yes, __Daily __Weekly __Monthly __Occasionally __Socially

Recreational/Drug Usage: __Yes __No Type/Amount/How Often: _____

Allergies : __None __Yes, list →

Latex Allergy/Sensitivity? __Yes __No

Metal Allergy? __Yes __No

Shellfish Allergy? __Yes __No

Medication/Food	Allergic Reaction

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Patient Signature: _____ Date: _____

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Patient Name:_____

Date of Birth:_____

HEALTH HISTORY

Review of Systems

Review of Systems *(recent or current conditions only)*

CONSTITUTIONAL:
- ☐ ***NONE***
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Chills

CARDIOVASCULAR:
- ☐ ***NONE***
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Irregular Heartbeat/ Palpitation
- ☐ Leg Swelling
- ☐ Fainting

INTEGUMENTARY:
- ☐ ***NONE***
- ☐ Itchy skin
- ☐ Rash
- ☐ Skin Infections
- ☐ Skin Lesion
- ☐ Contact Allergy

METABOLIC/ ENDOCRINE:
- ☐ ***NONE***
- ☐ Hair Loss
- ☐ Heat Intolerant
- ☐ Cold Intolerant

HEAD, EYE, EAR, NOSE & THROAT:
- ☐ ***NONE***
- ☐ Blurred / Double vision
- ☐ Difficulty Swallowing
- ☐ Ear Drainage
- ☐ Facial Pain
- ☐ Headache
- ☐ Hearing Loss
- ☐ Nasal Congestion
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Vision Loss

GASTROINTESTINAL:
- ☐ ***NONE***
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Frequent Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

NEUROLOGICAL:
- ☐ ***NONE***
- ☐ Difficulty Walking
- ☐ Dizziness
- ☐ Poor Coordination
- ☐ Memory Loss
- ☐ Muscle Weakness
- ☐ Seizures
- ☐ Tremors
- ☐ Tingling

PSYCHIATRIC:
- ☐ ***NONE***
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

HEMATOLOGIC:
- ☐ ***NONE***
- ☐ Bleeding
- ☐ Bruising

REPRODUCTIVE:
- ☐ ***NONE***
- ☐ Pregnant

RESPIRATORY:
- ☐ ***NONE***
- ☐ Cough
- ☐ Dyspnea (Difficulty Breathing)
- ☐ Recent Infections
- ☐ Known TB Exposure
- ☐ Wheezing
- ☐ Shortness of Breath

GENITOURINARY:
- ☐ ***NONE***
- ☐ Dysuria (Painful Urination)
- ☐ Frequent Urination
- ☐ Hematuria (Blood in Urine)
- ☐ Urge Incontinence
- ☐ Urinary Incontinence

IMMUNOLOGICAL:
- ☐ ***NONE***
- ☐ Asthma
- ☐ Contact Dermatitis
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies
- ☐ Bee Sting Allergies

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HEALTH HISTORY

History of Present Illness

Patient Name:_____ Today's Date _____

Date of Birth:_____

What body part(s) are involved?

_____

_____

_____

On a scale of 0 through 10 (10 being worst), **how severe is your pain?**

0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain?

□ Sharp □ Dull □ Stabbing □ Throbbing □ Aching □ Burning

□ Constant □ Intermittent □ Wakes me from sleep

□ Other _____

Describe: _____

_____

Do you have?

□ Swelling □ Numbness □ Tingling □ Weakness □ Bruising

□ Other _____

Have you had any Physical Therapy for this condition? □ Yes □ No

Where: _____ Dates: ____/____/_____ to _____/____/____

Have you had an MRI, CT or X-Rays for this condidtion? □ Yes □ No

Which study? □ MRI □ CT □ X-Rays Where: _____

Date: ____/____/_____

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MEDICATION RECORD

Please complete the following information for review by your provider.

Name: _____ Birth Date: ____/____/____ Age: _____

Today's Date: _____

Medications you currently take (including over the counter medications, vitamins, herbs, & prescribed drugs):

☐ See separate medication list

Date	Name of Medication	Dosage/Frequency	*Additional Information*

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that I have received a copy of the MOS Notice of Privacy Practices. I understand that MOS has the right to change its Notice of Privacy Practices from time to time and that I may contact MOS at any time to obtain a current copy of the Notice of Privacy Practices.

Signature of Patient/Guardian: _____ Date: _____

Relationship to Patient: _____Patient's Date of Birth:_____

Protected Health Information (PHI) Release Authorization

Persons who are involved in your care (spouse, children, friends, etc.) may inquire about your treatment, appointments, lab results, prescriptions, billing, medical records, x-rays, etc. Please list the individuals who we may share your PHI with:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

**** Please note that MOS will only release PHI to the individuals listed above ****

I, _____, acknowledge in signing this document that I am giving Muir Orthopaedic Specialists authorization to release or discuss PHI either in writing or verbally to the person(s) specified above. This authorization is good indefinitely from the signature date below unless otherwise revoked by me in writing to the address listed below. A copy of this will be placed in my records at Muir Orthopaedic Specialists.

Signature of Patient/Guardian: _____ Date: _____

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PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

Your confidential healthcare information may be released to other healthcare professionals or other treating physicians for the purpose of providing you with quality healthcare.

Your confidential healthcare information may be released to your insurance carrier and/or treating vendor for the purpose of the practice receiving payment for providing you with needed healthcare services. If you pay out of pocket and in full for a health care item or service, then you have the right to restrict certain disclosures of your protected healthcare information to your health insurance. Ask us how to do this.

Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.

Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).

Your confidential healthcare information may be released to certain parties only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

You may be contacted by Muir Orthopaedic Specialists to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. If you are not home, we may leave appointment information on your answering machine or in a message left with the person answering the phone.

We may use and disclose limited protected health information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

You have the right to restrict the use of your confidential healthcare information. However, Muir Orthopaedic Specialists may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

You have the right to receive confidential communication about your health status, such as changing your mailing address or telephone number.

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You have the right to review any/all portions of your healthcare information upon written request within the timeframes set by California law.

You have the right to receive an electronic or paper copy of your medical record upon written request within the timeframes set by California law. We may charge a reasonable, cost-based fee.

You have the right to request changes be made to your healthcare information. We may say "no" to your request, but we'll tell you why in writing within 60 days.

You have the right to know if certain parties have accessed your confidential healthcare information and for what purpose.

You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice. If we suspect your confidential healthcare information has been disclosed without authorization, you have the right to receive notification of a breach. We will send you a written notice with instructions on how to protect yourself from potential harm resulting from the breach, if it has occurred.

Muir Orthopaedic Specialists is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients, upon request, with a list of duties or practices that protect confidential healthcare information.

Muir Orthopaedic Specialists will abide by the terms of this notice. The practice reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Any changes to this notice will be posted in our practice and on our website (www.muirortho.com) within 30 days of making any changes.

You have the right to file a complaint to Muir Orthopaedic Specialists if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the center:

ATTN: Katie Smith – Privacy Officer
Muir Orthopaedic Specialists
2625 Shadelands Drive
Walnut Creek, California 94598

All complaints will be investigated. No personal issue will be raised for filing a complaint with Muir Orthopaedic Specialists. Also, you have a right to file a complaint with the Department of Health and Human Services. You may visit their website at www.hhs.gov to file a

complaint or call the regional HHS Office of Civil Rights at (415) 437-8310 for information on how to file a complaint.

For further information about this Privacy Notice, please contact:

Katie Smith, Privacy Officer
Accounting Department Manager
(925) 210-8570
privacy@muirortho.com

MOS Privacy Notice is effective as of 4/14/03.
Revised 6/19/2013
Revised 9/23/2013
Revised 5/3/2016

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Financial Policy

Thank you for choosing Muir Orthopaedic Specialists. We are committed to delivering outstanding orthopaedic care and customer service. The following is our current financial policy.

Co-Payment & Co-Insurance Collection Policy

We are required by our contract with your health plan to collect co-payments at the time of service. Co-payments are required each time you are seen by the physician, nurse practitioner, physician's assistant, physical therapist or occupational therapist. Your co-payment is established by your health plan and is explained in your benefits handbook. Should you have questions or concerns about your co-payment requirements, please contact your insurance carrier directly.
If a co-payment is not applicable for office visits we may collect co-insurance amounts at the time of service. The co-insurance amount is calculated based on the percent that you will owe per your health insurance policy. We collect $10 for every 10% co-insurance for office visits. For example if you have a 20% co-insurance we will collect $20 at the time of service. Since this is an estimate you may owe more once your insurance carrier processes your claim.

Insurance Reimbursement & Billing Policies

We will bill your insurance as a courtesy to you. Each month you will receive a statement from us describing your current balance and any charges incurred during the statement month. You can submit this bill yourself, along with the appropriate forms, to your insurance carrier. Or, as most of our patients prefer, we will bill your primary and secondary insurance carrier(s) for you. For us to be able to bill your insurance carrier, you must sign the "*Insurance Authorization and Assignment*" statement at the bottom of the *Patient Information* form. We will bill your insurance carrier a maximum of **three (3) times**, then the responsibility for handling issues with insurance reimbursement rests with you. **Please note that you are ultimately responsible for payment of all charges incurred during your treatment with Muir Orthopaedic Specialists.**

When you receive our monthly statement, payment is expected within **fifteen (15) days**. Account balances are considered delinquent after **sixty (60) days**. After sixty (60) day period, your account will be transferred to our outside collection agency, Joben Enterprises, unless alternative payment arrangements are made in writing with an accounting department representative.

If Muir Orthopaedic Specialists or its physicians are ***not*** contracted with your insurance carrier, you are considered a "self-pay" patient and payment is due in full at the time of service. Self-Pay patients will receive a 20% discount off of our Standard Fee schedule.

Attorney Fees and Collection Costs: If any legal action is necessary to enforce or interpret the terms of these billing policies, the prevailing party shall be entitled to reasonable attorneys' fees, costs and necessary disbursements in addition to any other relief to which that party may be entitled. You agree by your signature below to pay all collection costs, including attorneys' fees on all delinquent payments.

Suspension of Care (Except for Emergency Care): If no payment is received after ninety (90) days, we may be forced to suspend all but emergency care until a payment is received. Please discuss all billing issues with our accounting department directly at (925) 210-8593.

Administrative Fees

Due to the high volume of requests we receive, we charge administrative fees for copying all or part of a medical record, x-rays, MRI, CT, completion of disability forms, and other such administrative requests. The current fee schedule (which is subject to change) is:

Disability Forms:	$25.00 / $10.00 (*EDD extension form*)	**Medical Records**:	$20.00
Diagnostic Images:	$15.00 (*x-rays*) / $15.00 (*MRI or CT scan*)	**Returned Check Fee**:	$25.00
EMG & Epidural No-Show/Cancellation Fee:	$50.00 (for EMG/Epidural appointments not cancelled within 48 hours of scheduled time)		

My signature below indicates that I have read, understood and agreed to the Financial Policy of Muir Orthopaedic Specialists, A Medical Group, Inc.

Patient/Guardian Signature: _____ Date:_____

Patient/Guardian Name Printed: _____ Patient's Date of Birth:_____

Updated - effective 6/1/2014 ks

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Muir Orthopaedic Specialists
Patient Education: Opioid Drugs for Pain

Introduction

This document contains important information about the medication your surgeon may prescribe to control your pain. We are providing this information to ensure that you are clear about the pain relief and function goals that your physicians wants to achieve with your treatment plan.

Opioids do not work for everyone and have serious risk and possible side effects. Opioids may provide pain relief but are unlikely to take the pain away completely. Your surgeon and you will determine if the benefit of pain medication outweighs the risk and possible harm.

Our Orthopedic and Physical Medicine & Rehabilitation surgeons do not provide long-term pain control for chronic conditions. Your prescription for pain is for **short term** post-operative or post-trauma pain control. Patients needing long term chronic pain control will be referred to a Pain Management Specialist.

It is very important that you read this information carefully and understand the material. If you do not understand or have questions be sure to ask your surgeon or pharmacist prior to taking the drug.

Alternative to Help Reduce Pain

Opioids are part of a pain plan that can help control your pain. These options can work in place of or together with your Opioid to control your pain and improve your function.

Heat and Cold therapy	Relaxation Therapy
Stretching	Physical Therapy
Exercise	Occupational Therapy
Weight Loss	Mental Health Therapy
Massage	Non-opioid pain medications
Acupuncture	Injections
Nerve Stimulation	Specialist Pain Care
	Spiritual or Social Activities

Side Effects

In addition to the serious risks of addiction, abuse, and overdose, the use of prescription opioid pain relievers can have a number of side effects, even when taken as directed:

- Tolerance – meaning you might need to take more of the medication for the same pain relief
- Physical dependence – meaning you have symptoms of withdrawal when the medication is stopped
- Increased sensitivity to pain
- **Constipation**
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength

- Itching and sweating

Your Responsibilities when taking Opioids

- ✓ Take your prescription as directed.
  - o Do not take other people's prescription or allow others to use your prescription. This is dangerous, illegal, and can lead to criminal charges.
  - o Do not delay taking as directed or take more than is prescribed. Early refills will not be allowed.
- ✓ Be cautious about driving or operating machinery.
  - o You may feel sleepy or confused after taking opioid medication.
- ✓ Do not drink alcohol or take 'street drugs'.
  - o Alcohol or street drugs combined with your medication can cause severe harm or death.
- ✓ Keep your medication in a safe and secure place out of reach of children, visitors, other family members, and pets.
  - o We will not replace lost or stolen medication.
  - o It is illegal to sell or give your opioid medication to another person.
  - o Always store your prescription in the original labeled container.
- ✓ Inform all of your treating physicians that you are prescribed an opioid.
  - o Do not obtain opioids from more than one physician at a time.
  - o Be sure that you have informed us of all other medications or drugs (legal or illegal) that you are taking.
- ✓ Opioid Prescriptions cannot be electronically ordered or called into a pharmacy.
  - o You must pick up a printed prescription from our office. An ID will be required.
  - o Others picking up your prescription is discouraged and limited; contact our office to determine if allowed for a special circumstance.
  - o Any refills require you to make an appointment to assess pain control.
  - o Opioids will not be refilled after hours, weekends, or holidays. Plan ahead for refills.
- ✓ Dispose of unused medications in the proper way. **Never flush your medication**.
  - o Check with your pharmacy if they participate in a medication disposal program.
  - o If your pharmacy does not participate in a medical disposal program, you can dispose your medications at the following sites in the East Bay. Before you do so, first seal bottled liquids in a plastic bag and don't include syringes or needles with medications.

    Antioch, Delta HHW Collection Facility (East County)
    2550 Pittsburg-Antioch Highway

    Brentwood Police Department
    9100 Brentwood Blvd

    Clayton Police Department, City Hall
    6000 Heritage Trail

Concord Police Department
1350 Galindo Street

Danville Police Department
510 La Gonda Way

Martinez Contra Costa Sheriff's Field Operations Building
1980 Muir Road

Martinez County Regional Medical Center
2500 Alhambra Avenue

Martinez Police Department, City Hall
525 Henrietta Street

Moraga Police Department
329 Rheem Boulevard

Orinda Police Department, City Hall
22 Orinda Way

Pleasant Hill Police Department
330 Civic Drive

Richmond Contra Costa County Household Hazardous Waste (HHW)
West County Resource Recovery
101 Pittsburg Avenue

San Ramon Police Department
2401 Crow Canyon Road

Walnut Creek Police Department, City Hall
1666 North Main Street

- Anyone in Contra Costa can find a nearby drop-off kiosk to safely dispose of unwanted prescription or non-prescription drugs by visiting med-project.org. A mail-back service is available for people who have disabilities that affect their mobility. These services are part of Contra Costa's Safe Drug Disposal Ordinance, which requires companies that make pharmaceutical drugs sold in the county to follow the MED-Project plan for safely collecting unwanted or unused medicine.

Patient Name:_____

Date of Birth:_____

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CONTROLLED SUBSTANCE MEDICATION AGREEMENT

I understand that a provider with Muir Orthopaedic Specialists may prescribe a controlled substance medication. This agreement is a platform for communication allowing us to work together in good faith, and for you to understand the importance of this medication in allowing you to function better. We expect to be partners in creating the best treatment plan for your pain management. If you cannot agree with the following points, it will result in discontinuing the controlled substance.

1. I will take my medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my physician.

2. I will keep regular scheduled appointments with my physician. Any refills for a controlled substance medication require you to schedule an appointment to assess pain control. Please call 925.939.8585 to schedule an appointment **well in advance of needing a refill**. Your physician or the physician on call for the group will not refill any pain medication after hours or over the weekend. This is not considered an emergency and will not be treated as such.

3. The controlled substance medication prescribed is being given in order to control pain and allow you to function better. If there are any changes to your activity level or physical condition the treatment may be changed or discontinued.

4. I will be ready to taper or discontinue the controlled substance medication as my condition improves. If your condition does not improve, your physician may recommend additional conservative or invasive orthopedic procedures. If your level of pain does not allow you to taper and discontinue the controlled substance pain medication, you will be referred to a pain management specialist.

5. I agree to act responsibly including protecting and limiting access to these medications, and to properly dispose of any unused medication.

6. I will not accept or seek controlled substance pain medication from any other physician or health care provider, including an emergency room, while any MOS physician is prescribing pain medication. It is essential that only one physician monitor and evaluate your pain medication.

7. If you have another condition that requires the prescription of a controlled substance medication (narcotics, tranquilizers, barbiturates, or stimulants) you will be asked to coordinate all medications with that prescribing physician.

8. It is important to use one pharmacy for all prescriptions in order to provide consistency. Please list your pharmacy_____ Phone_____

9. I understand that lost, stolen, or misplaced prescriptions will not be replaced. This medication is prescribed for you and only your needs for pain control. To allow others to use your pain medications is illegal and dangerous; this behavior will not be tolerated by your physician and our practice.

10. I agree that I will not use any other illegal and/or recreational drug while receiving care and pain medication from this practice. Use of illegal and/or recreational drugs, especially while taking pain medication is extremely dangerous and potentially lethal.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Witness Signature: _____ Date: _____