Muir Orthopaedics PT and Rehab
2405 Shandelands Dr. #100, Walnut Creek, CA 94598
(92S) 210-8500

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 Orthopeadic Specialists. Authorization is herby 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 Orthopeadic Specialists, I hereby instruct and direct Muir Orthopeadic 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 Orthopeadic 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 _____.

Patient Name

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date