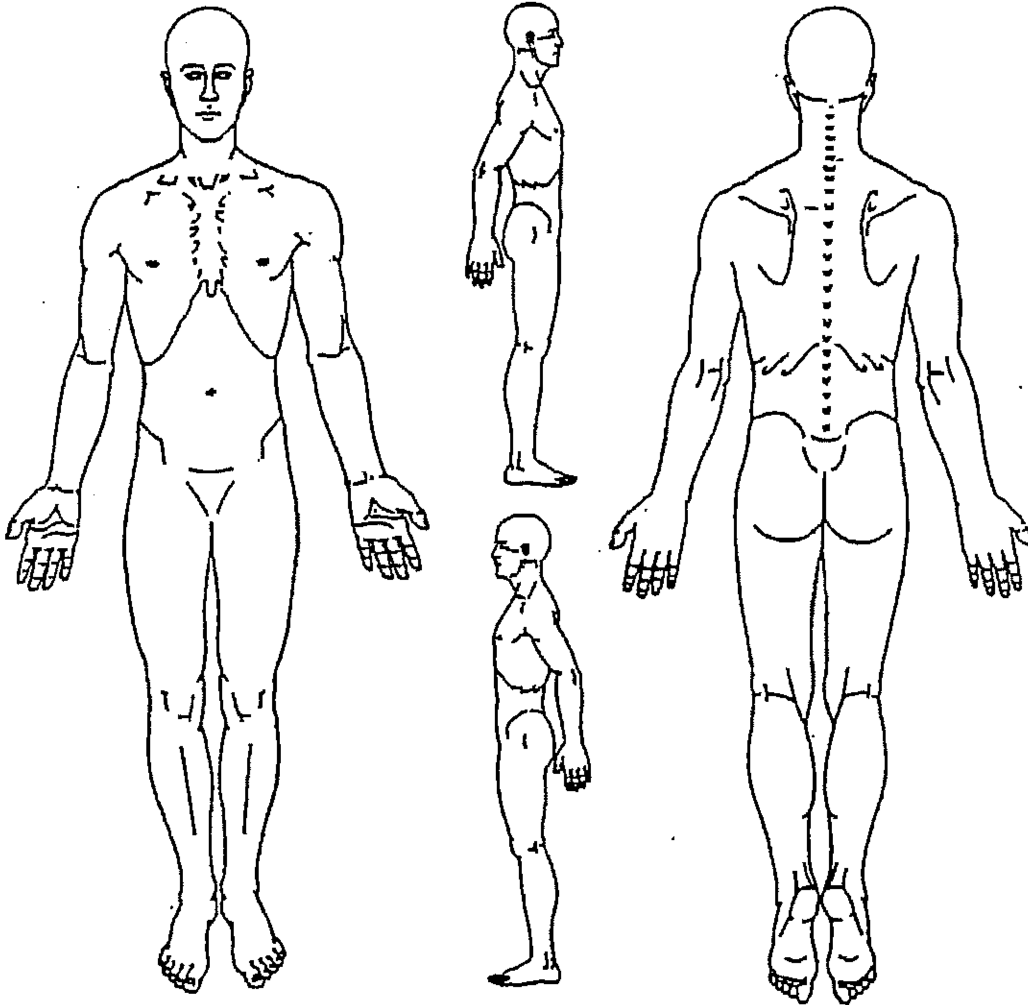
Patient Name: ______________________________

Date of Birth: ______________________________

WHERE IS YOUR PAIN NOW?

Mark the areas on the diagram below where you feel the described sensation using the appropriate symbol:

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
AAA	OOO	---	XXX	///



VISUAL ANALOG SCALE (VAS)

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

No Pain ____ Worst Pain

ARE YOU NOW: BETTER:_____ WORSE:_____ SAME:_____ SINCE THE PROCEDURE/ INJURY

Signature:____ **Date:**____________

MUIR ORTHOPAEDIC SPECIALISTS

Physical Therapy & Rehabilitation Department

Patient Name: ______________________________

Date of Birth: ______________________________

Notice of financial interest to the patient:

1) As a patient, you may seek physical therapy treatment services from a physical therapy provider of your choice who may not necessarily be employed by this medical corporation.

2) Your referring physician is an owner or employee of this medical corporation.

Acknowledged by:

______________________________ ______________________________

Patient / Guardian Signature Date

Leading Edge Care. Old Fashioned Caring.

Mailing Address P.O. Box 31396 Walnut Creek, CA 94598
Walnut Creek Corporate Office 2405 Shadelands Drive, Suite 110 Walnut Creek, CA 94598 Tel 925.210.8500 Fax 925.933.9184
San Ramon Office 5201 Norris Canyon Road, Suite 300 San Ramon, CA 94583 Tel 925.210.8530 Fax 925.866.8741
Brentwood Office 350 John Muir Parkway, Suite 100 Brentwood, CA 94513 Tel 925.516.8443 Fax 925.516.3354

Patient Name: ____________________

Date of Birth: ____________________

MOS Physical Therapy & Rehabilitation

AUTHORIZATION FOR OUTPATIENT TREATMENT

I have been informed of the treatment considered necessary and the treatment and procedures will be performed by appropriately licensed therapists, occupational therapists, chiropractors, athletic trainers, physical therapy assistants, and exercise physiologist or other assistants employed by MOS PT and Rehab. Authorization is hereby granted for such treatment and procedures as prescribed by my physician, or directed under California "Direct Access".

I understand and acknowledge that as part of my treatment, I will be engaging in physical exercises and using exercise equipment and as with all such physical activity there is an inherent risk of injury or using complication to my existing condition. I am voluntarily participating in these physical activities and knowingly and freely assume all risks of injury, or loss or damage on account of these activities. I understand results are not guaranteed and I have the right to discuss the purposes and risks associated with all recommended treatment procedures and activities with my therapist.

I certify the information provided to MOS PT and Rehab by me is correct, and I accept full responsibility for all charges*. I hereby assign and authorize payment directly to the above named clinic of all applicable insurance benefits. If my current policy prohibits direct payment to MOS PT ad Rehab, I hereby instruct and direct MOS PT and Rehab to bill me directly for insurance payments made to me. I understand 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.

*Patients with valid workers' compensation claims are not responsible for treatment charges

MEDICAL RECORDS AUTHORIZATION

MOS PT and Rehab is hereby authorized to release information pertinent to my treatment to any doctor, insurer, compensation carrier, attorney or other agency legally involved with my care (proof of relationship will be confirmed).

MEDICARE PATIENTS

I certify the information provided to MOS PT and Rehab by me in applying for payment under the 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 payment of authorized benefits be made on my behalf. I understand Medicare may not pay for physical or occupational therapy services over $1,940 unless my condition qualifies for a cap exception.

I authorize MOS PT and Rehab 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
____________________	____________________	
Patient / Guardian Signature	Name of Minor (print)	

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MUIR ORTHOPAEDIC SPECIALISTS

SPECIALIZED • INNOVATIVE • COMPASSIONATE

Name: ______________________ DOB: __________ Date: ___________

Please answer the following questions to aide in our compliance with required Quality Reporting healthcare regulations:

Height: ______________________ Weight: ______________________

Please list all current Medications:

____

____

____

____

____

____

____

____

____

____

What level is your pain (0-10) Low ___ High ___ Average ___

Have you had any falls in the last year? YES/NO

If so, how many? ______________________

Did any of these falls result in an injury? YES/NO

Injury details: ______________________

P 925.210.8500 • F 925.933.9184 • www.muirortho.com

Office Locations: Brentwood • Concord • San Ramon • Walnut Creek

Mailing Address: PO Box 31396 • Walnut Creek, CA 94598