LAST NAME	FIRST NAME	INITIAL	SEX	DOB

- I authorize *Newton Wellesley Orthopedic Associates, Inc***.** to release any information acquired during this examination or treatment to the insurance carrier.

- I also hereby authorize and direct payment of all medical/surgical benefits directly to *Newton Wellesley Orthopedic Associates, Inc.* I understand this assignment does not lessen my financial responsibility for any charges not covered by this authorization.

Payment due over 30 days are assessed a late fee of 1 ½% per month (18% annually). A $30 fee will be added to all returned checks.

By signing this form I acknowledge the receipt of *NWOA* **Notice of Privacy Practices** which provides me with detailed information about how *NWOA* may use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

Patient Signature Date

*** If your insurance carrier requires a referral for visits to a specialist, we must have a valid referral on file at the time of service ***