

NWOA

NEWTON WELLESLEY ORTHOPEDIC ASSOCIATES

PRIMARY CARE PHYSICIAN		W/C	Y	N	AUTO?	Y	N	
PATIENT INFORMATION								
LAST NAME		FIRST NAME		INITIAL	SEX	DATE OF BIRTH		
STREET ADDRESS		CITY		STATE	ZIP CODE	MARITAL STATUS S M W D		
HOME PHONE ()	WORK PHONE ()		CELL PHONE ()					
SOCIAL SECURITY NO.								
NEXT OF KIN					PHONE ()			
RELATIONSHIP								
INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)								
LAST NAME		FIRST NAME		DOB	RELATIONSHIP TO PATIENT			

AUTHORIZATION

I authorize *Newton Wellesley Orthopedic Associates, Inc.* to release any information acquired during the course of this examination or treatment to the insurance carrier. I also hereby authorize and direct payment of all medical/surgical benefits directly to the *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 1/2% 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***