LAST NAME	FIRST NAME	DOB

CONSENT TO TREAT

I authorize Newton Wellesley Orthopedic Associates to release any information acquired during this examination or treatment to my insurance company.

I understand that my Managed Care Plan requires that my Primary Care Physician authorize and complete an insurance referral for visits to a specialist. If this procedure has not been followed and the appropriate insurance referral is not in the office at the time of visit, I will be accountable for payment for this service, or may be rescheduled until said referral is in place.

Patients of Newton Wellesley Orthopedic Associates are required to provide current insurance information. If accurate insurance information which includes primary and secondary insurance is not provided on the date of your visit, I will be held financially responsible for payment of this visit.

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Patient Signature Date