UXBRIDGE
Orthopedic & Sports Therapy
At Lydia Taft House

Please provide us with the following information:

First Name _____ M.I. _____ Last Name _____

Telephone (home) _____-_____-_____ Date of Birth _____-_____-_____

~ PLEASE PROVIDE ORIGINAL INSUARNCE CARDS OR CLEAR COPIES OF FRONT AND BACK OF CARDS ~

I. AUTHORIZATION OF BENEFITS: I hereby assign all health insurance benefits to LYDIA TAFT HOUSE for Outpatient Rehabilitation services rendered. This assignment includes benefits payable by Medicare and all other health insurance programs, which the above named patient is a beneficiary. I authorize the release of any pertinent information that is relevant from all sources necessary to secure payment for services rendered.

INITIALS: [ ]

II. CONSENT TO TREAT: I hereby give consent to the Authorities of LYDIA TAFT HOUSE to provide Outpatient Rehabilitation services to me. I understand that it is my responsibility to obtain a referral from my doctor prior to receiving treatment. I do also hereby for myself, my heirs, executors and administrators, waive, release and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this service.

INITIALS: [ ]

III. PAYMENT CONSENT: I hereby understand fully that if my insurance company denies payment for services rendered that the bill will become my responsibility and I will be billed for services here at LYDIA TAFT HOUSE.

INITIALS: [ ]

IV. NOTIFICATION OF PRIVACY POLICY: I hereby acknowledge that I have been informed of the Policy on Notice of Privacy Practices observed by LYDIA TAFT HOUSE. I understand that I may obtain a copy of LYDIA TAFT HOUSE'S Privacy Practices/Patient's Privacy Rights from the business office upon request.

INITIALS: [ ]

V. COPAYS: I hereby acknowledge that I have been informed that I am responsible for **copays to be paid at the time of service**. I am aware if I show up to my scheduled appointment without my copay I will be asked to reschedule that appointment.

INITIALS: [ ]

VI. RETURNED CHECK POLICY: I hereby acknowledge that there will be a $25.00 fee for insufficient funds on each returned check. I do also hereby that cash will only be accepted from that point on for future co-pays.

INITIALS: [ ]

_____ _____ _____
Signature of Patient (or Responsible party) Print Full Name Clearly Date

_____
Relationship to Patient (if signing for patient)

_____ _____ _____
Witness Signature Print Full Name Clearly Date