PATIENT WAIVER

May we leave information on your answering machine? Yes_____No_____

May we leave information with someone at your home? Yes_____No_____

I hereby authorize Worcester County Orthopedics to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Worcester County Orthopedics all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for payment if I have not fulfilled their requirements.

Signature_____ Date_____

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment, as may be deemed necessary by Worcester County Orthopedics and/or its designees.

Signature_____ Date_____

PLEASE HAVE YOUR INSURANCE CARD AVAILABLE TO PHOTOCOPY