



Daniel Curtin, MD

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Patient Registration Form Disclosures And Consents

Patient Name: _____ Date Of Birth _____
First Name M.I. Last Name

Assignment Of Insurance Benefits

I hereby authorize direct payment of my insurance benefits to Wayland Family And Sports Medicine, P.C.; or the Physician individually for services rendered to my dependents or me by the Physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Wayland Family And Sports Medicine, P.C. is unable to collect from my insurance carrier for any reason.

Medicare/Medicaid/CHAMPUS Insurance Benefits

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Wayland Family And Sports Medicine, P.C., or the Physician, on my behalf.

Authorization To Release Non-Public Personal Information

I certify that I have received and read a copy of Wayland Family And Sports Medicine, P.C.'s Patient Privacy Policy. I hereby authorize Wayland Family And Sports Medicine, P.C., or the physician individually, to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical treatment, evaluation, or the processing of insurance benefits.

Authorization To Mail, Call or E-Mail

I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize a Wayland Family And Sports Medicine, P.C. representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to appointment reminders, referral arrangements or laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Wayland Family And Sports Medicine, P.A. to that effect in writing.

Lab/X-Ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am responsible for any co-pay or balance due for these service if they are not reimbursed by my insurance for whatever reason.

Consent To Treatment

I hereby consent to evaluation, testing and treatment as directed by a Physician affiliated with Wayland Family And Sports Medicine, P.C. or his or her designee.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____
(If different from patient)