



1. I hereby authorize Connecticut Spine & Rehab, LLC to obtain any information which may have been acquired by examination or other means regarding my physical condition, and thereby release them of any consequences thereof.
2. I acknowledge that I have received and or read the Privacy Statement acknowledgement of Connecticut Spine & Rehab, LLC.
3. I hereby authorize release of information necessary to file a claim with my insurance company.
4. I understand the Doctor may administer services uncovered by my insurance company, which I will be responsible for.
5. I understand that I am solely responsible for any outstanding balances due to Connecticut Spine & Rehab, LLC upon completion of my treatment.
6. I assign insurance benefits otherwise payable to me, to Connecticut Spine & Rehab, LLC.

Date: \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_

Patient Name

\_\_\_\_\_

Patient Signature