CHELSEA CLINIC LLC.

330 Washington St Suite 420
Norwich, CT. 06360

RELEASE OF INFORMATION AND AUTHORIZATION OF BENEFITS FORM

Patient Name:_____(please print)
Account #_____

I authorize Chelsea Clinic LLC to release medical information, or anything pertaining to the examination, treatment, history, and medical expenses including pre-existing condition information to my insurance company(ies) and /or its acting intermediary or agent, or employer/compensation carrier(s), or it's legal representative for the purpose of processing insurance claims. This release may include reviewing and /or photo copying pertinent documents for the purpose of payment by your insurance company.

I authorize release of medical information to physicians or health practitioners (for example, Physical therapists) to who I may be referred.

I authorize payment of medical insurance benefits* to be made directly to Chelsea Clinic LLC. I permit a copy of this authorization to be used in place of the original.

I agree to accept full financial responsibility for payment of charges rendered to the above patient. I understand that if Chelsea Clinic LLC. does not participate with my insurance I will be responsible for all charges not paid by my insurance.

I further agree to pay the cost of collections and/or attorney's fees in the event this account is referred to a collection agency or attorney. Chelsea Clinic requires a 24-hour advanced cancellation notice, failure to notify the office will result in a $75.00 no show fee effective October 13, 2003.

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with the effective date below.

Patient or guarantor signature date

If guarantor, indicate relationship to patient

*For Medicare patients, this applies to The Social Security Administration or its intermediaries, or carriers.
*For Blue Shield of Connecticut, this applies to a covered service rendered by a participating physician only.

Rev-10/03