Back On Track

Physical Therapy

1180 Beacon Street 6C
Brookline, Massachusetts 02446
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GROUP HEALTH INSURANCE AFFIDAVIT/WAIVER

1. I am a resident of the state of ___________________________________ (State)

2. I was injured on _________________
(Date of Accident)

(Please check only ONE below)

______ At the time of injury **I DID** have health insurance coverage. I understand that if my health insurance policy requires a referral or authorization for treatment that I will obtain said referral or authorization from my primary care physician. If I do not secure authorization for treatment as described above I understand that I remain solely responsible for the balance of all treatment charges.

______ At the time injury **I DID NOT** have health insurance coverage of my own or through any household member for this treatment.

____________________________	____________________________	______________
Patient's Signature (Parent/Guardian if patient is a minor)	Print Name	Date

____________________________	____________________________	______________
Witness	Print Name	Date