Sweeney Dawley Recovery Center, LLC
Ethel Marie Dawley
409 Pond Street, Suite 9
Braintree, MA 02184
Phone 781-268-2638
Fax: 781-268-2681

Name:		
Street:		
City:	State:	Zip Code:
DOB:	Gender:	
Social Security #:		
Cell Phone:	Alternate Phone:	
Email:		
Name of Referral Source:		
Pharmacy Name, Address and Phone #:		
Employer:		
Insurance Company		
Subscriber:	Subscriber DOB:	
Subscriber Social Security:		
Policy Number:		
Insurance Address:		
Insurance Phone Number:		
Emergency Contact Name, Relationship & Phone#:		

Please read the following office policy carefully. Copayments and deductibles are due at the time of service. A receipt will be provided to you for submission to your insurance company upon your request. If your insurance does not pay you will be responsible for the following.
New Patient $300.00
Follow up $175.00
The client is directly responsible for all fees for missed appointments.
Appointments must be cancelled 24 hours in advance.
Missed Appointment or Same Day Cancellation are a $75.00
I have read and agree with the above payment conditions. I hereby authorize the provider of service to release any medical or other information necessary to process the insurance claim(s). I hereby assign to the provider all payments for services rendered to myself and or dependents. I understand that I am responsible for any amount not covered by my insurance company. I further understand I am responsible for obtaining any authorization, precertification, or referral required by my insurance company prior to any service. I understand failure to do so will result in my responsibility for the full payment of services not allowed as a result of my failure to obtain prior authorization, precertification or referral. I also understand that it is my responsibility to notify Sweeney Dawley Recovery Center, LLC of all insurance policy changes, that may impact the payment of Sweeney Dawley Recovery Center, LLC, within 14 days of the coverage change. I understand I am responsible for all covered and non-covered charges that are not paid by my insurance company due to my lateness in supplying Sweeney Dawley Recovery Center, LLC of my policy changes.

Signature: _____ Date:_____

To be completed by Provider: Diagnosis :_____

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