Westport Weston
Health District
180 Bayberry Ln Westport, CT 06880
P: 203.227.9571 F:203.221.7199

Name (Last, First):_____ Date of Birth (____/____/_____)

Street Address:_____City:_____

State: _____ Zip:_____

Phone number:_____

Email: _____

Primary Insurance

Insurance Company name:_____

ID# _____
Group: _____

Insurance Address:_____

Secondary Insurance

Insurance Company name:_____

ID# _____
Group: _____

Insurance Address:_____

Consent to treat and consent to bill insurance:
By Signing this document, you are stating that all the information above is accurate and true. You agree to allow the Westport Weston Health District (WWHD) and Quest Diagnostics to use the above information for billing purposes and consent to allow the WWHD staff collect a lab specimen to be sent to quest. You understand that Quest will bill your insurance and possibility you in order to perform lab testing. You are in understanding that the WWHD will keep your information confidential and will follow all HIPPA laws. WWHD's Hippa policies can be found posted in the clinic, on the website, and given upon request.

Name:_____Signature:_____Date:_____