MILE HIGH OTOLARYNGOLOGY, LLC

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Patient Referral Waiver Agreement

When my Primary Care Physician referred me to this office, I understand they were given an authorization number and a copy of the referral form. This was also to be mailed to me and the office. IF I DO NOT HAVE A COPY OF THE REFERRAL FORM WITH ME AT THIS TIME OR, IF THIS OFFICE HAS NOT RECEIVED THEIR COPY YET, I REALIZE I HAVE THE FOLLOWING OPTIONS:

1) I can call my Primary Care Physician and get the Authorization number for this visit: #_____

2) I can reschedule this appointment and bring my copy of the referral form or the Authorization number with me to that appointment, or:

3) I can keep this appointment today, without either of the above, and I understand That my insurance company may NOT PAY for the charges related to my visit today.

   Further, I understand that I will be responsible for the payment of ALL CHARGES related to my visit today.

_____ _____

Printed Name of Patient/ Enrollee Date of Service

_____

Signature of Patient or Authorized Representative

_____

Member I.D. #