

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 the office and me.

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 referrathat appointment.	l form or the authorization number with me to	
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.		
Fui	Further, I understand that I will be responsible for the payment of ALL CHARGES related to my visit today.		
Pri	nted Name of Patient/Enrollee	Date of Service	
Sig	nature of Patient or Authorized Representative	Member I.D. #	