Referral Waiver Form

It is the responsibility of the member to obtain a referral from his/her PCP for specialty services. As of today, our office has not received a referral from your PCP.

Your signature below indicates that if you receive specialty care without a referral from your PCP, you may be financially responsible for such services should this be denied by your health insurance plan for lack of a referral from your PCP.

Patient Name: _____ Date: _____

Signature: _____

Signature of Parent/Guardian
if patient is a minor:_____

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