Orthopedic Associates, pa

PATIENT RESPONSIBILITY / NO REFERRAL

______________________________ ______________________________
DATE OF SERVICE DATE

Your insurance plan, _______________________________, requires a referral or
(Insurance Company)

authorization from your primary care on this date of service, physician
_____________________________, and does not provide for retroactive
(Physician's Name)
referrals.

I, ____________________________________, understand that I am being seen
(Patient Name)
or receiving services by the physician without a proper referral / authorization in place. If this referral is not received within 24 hours for the above date of service, I will be responsible for full payment of all charges incurred.

____
Please Print Patient Name

______________________________________ ________________________
Responsible Party Signature Date