

SPECIALIST TREATMENT WAIVER

I, _____, am a
(Patient Name)

_____ member, without the required
(Insurance Company)

referral/authorization number from my primary care physician. As result, I agree that I shall be responsible for payment in full for any charges related to services provided to me or my dependent at this office if I fail to provide the specialist with a referral/authorization number that was issued timely.

SIGNED: _____

DATE: _____

WITNESS: _____

This waiver is being used to ensure the integrity and purpose of the primary care physician referral/authorization process.