MILE HIGH
OTOLARYNGOLOGY

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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 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.

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2. I can reschedule this appointment and bring my copy of the referral form or the authorization number with me to that appointment.
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. #