FIRST Choice NEUROLOGY

Patient Responsibility Agreement/Referral Waiver

Patient Name:

Account Number:

Date:

I, _____, am a member of_____ (HMO) and I have scheduled treatment from _____ on_____ (date).

I do not have a referral letter or authorized referral number. I understand that the referral letter or an authorized referral number is required prior to scheduling this visit in order to assure that it is a covered benefit by my insurance carrier. I acknowledge that I do not have a referral for today's visit but elect to receive care.

The cost for today's visit will be $_____ due today. If you are able to obtain a referral after the fact for today's visit your money will be refunded to you AFTER YOUR INSURANCE PROCESSES THE CLAIM minus any deductible, copayments, or patient responsibility.

Signature of Patient or Guardian_____ Date _____

Signature of Witness_____ Date _____

•*This form is valid only for the date specified.*