Referral Waiver

I, _____ (Patient Name), understand the following:

1. My health insurance company requires a referral from my primary physician for any treatments and/or office visits performed at Capital Area Orthopedic Associates.
2. I am responsible for obtaining this referral from my primary physician before I can be seen by any provider at Capital Area Orthopedic Associates.
3. Should I be seen by any provider at Capital Area Orthopedics without a valid, current written referral I will be responsible for full payment for the visit.
4. I am responsible for all deductibles and co-pays at the time of service unless arrangements have been made in advance.
5. By signing this waiver I acknowledge that I fully understand these terms and agree to abide by them.
6. If I do not agree with these terms I will not be seen or treated at Capital Area Orthopedic Associates

Patient/Guardian Signature: _____ ___ Date: _____