

Insurance Coverage and Referral Waiver

I understand that my eligibility for coverage by _____ has not been verified at this time, but I want to receive medical services from Dr. Abramson.

I am aware that if my insurance is verified, there is a disclaimer, which states that they do not guarantee payment even though I may be eligible for benefits at the time of service. If it is determined that I am not eligible for coverage or that the medical services are not covered, I understand that I will be responsible for payment for all services provided.

I understand that if my insurance company requires a Referral from my Primary Care Physician's Office and I have not obtained that Referral and it has not been received before I leave the office, I am responsible for payment of all services rendered on the day of the visit.

Signature _____

Date _____