

UROLOGY ASSOCIATES, P.C.

535 Plandome Road Manhasset NY, 11030
Phone 516-627-6188 Fax 516-627-9397
<http://www.urologyassociatespc.com>

24 – HOUR REFERRAL WAIVER

Date _____

Patient Chart # _____

Patient Name _____

Patient Telephone # _____

Insurance Plan _____

Referring Doctor _____

Referring Doctor Tel # _____

I understand that my health insurance company requires that I obtain a **referral form** from my Primary care physician before I receive medical services from a specialist. I agree to obtain a referral form within **24 hours** of the date of my visit. If I do not provide Urology Associates, P.C. with a referral form, **I agree to be responsible for payment for all services rendered** and to be treated as an **out of network patient** responsible for all balances due.

By signing my name to this form I agree with the terms and conditions stated above.

Patient (or Guardian) Signature