Patient Responsibility Agreement/Referral Waiver

Patient Name:
Account Number:

Date:

I, _____, am a member of _____ (HMO) and I have scheduled treatment from Cancer Care of Western New York 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. I acknowledge that I do not have a referral for today's visit but elect to receive care. This required referral letter and/or authorization is to be obtained and delivered to the Provider's office within five (5) business days of the date of service; it should be backdated to the original date of service as noted above.

I also understand and agree that if I do not obtain the required letter and/or authorization within five (5) business days of the date of service and deliver it to the Provider's office, then I will be responsible for payment of charges and will be billed directly. The HMO will not be responsible for any charges connected with this unauthorized visit.

Signature of Patient or Guardian _____ Date _____

Signature of Witness _____ Date _____

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

This waiver is being used to ensure the integrity and purpose of the primary care physician referral system.