MOUNT AUBURN
HOSPITAL

PATIENT WAIVER FORM

❑ Referral Acknowledgment

I understand that I am required to obtain a referral from my Primary Care Physician (PCP) prior to going to a specialist and for some hospital based services. My insurance carrier determines when a referral is necessary.

If I do not have a referral on the date of service, I understand and agree that I will be financially responsible for all charges, hospital and physicians, that are not covered by my insurance company for this visit. I understand in some instances my PCP may approve a retro referral before initial billing activity takes place, and this referral follow-up is my responsibility.

❑ Primary Care Physician Acknowledgment

I understand that I am required to select and visit a Primary Care Physician (PCP) as part of my insurance plan coverage. To date, I have not selected a PCP and do not have a referral for my visit. Therefore, I understand and agree that I will be financially responsible for all charges, hospital and physicians, that are not covered by my insurance company for this visit.

❑ Acknowledgment that insurance may not cover services

I understand that my insurance may not cover all services. I understand that I will be financially liable for any services performed by the hospital that is not covered by my insurance.

Name of Test(s): _____

Insurance: _____

Patient's Name: _____ Acct. #: _____

Signature: _____ Date: _____

Staff Name: _____ Department: _____

** Please forward all waiver forms to the Manager of Patient Accounts, Clark Building basement.