



Referral Release

I understand that I may need a referral from my primary care physician for today's appointment. It is my responsibility to call my insurance company to determine if a referral is needed. I understand that it is my responsibility to obtain this referral. **If I do not obtain a referral from my primary care physician, I am responsible for any charges made to my account for my treatment.**

*This does not apply to patients with PPO plans.

Health Insurance Waiver for Non-Covered Services

Our office cannot tell you in advance whether or not your charges will be covered by your insurance plan. Each insurance company has multiple plans that vary with employer group contracts. **It is your responsibility to familiarize yourself with your own insurance plan, including types of coverage and restrictions on imaging and additional testing.** I understand that my health insurance may not cover certain services provided by Dr. Posner. Services not covered by your insurance will be billed to you. Should you have any questions regarding your coverage, it is your responsibility to verify your benefits with your insurance company prior to any scheduled appointment.

Name: _____

Date: _____