

WAIVER OF INSURANCE REFERRAL

My insurance is a managed care plan requiring a referral from my Primary Care Provider (PCP). I do not have the referral at the time of my office visit today and wish to proceed with treatment. I understand that if I do not obtain this referral or if my PCP will not provide one, I *will* be responsible for any and all charges incurred during my treatment at Phoenix Healthcare of Virginia, LLC.

DATE _____

Signed: _____
Parent/Guardian

PLEASE NOTE: *When you notify your PCP for a referral, the date on the referral must reflect the date you were seen. They cannot back date a referral for a previous date and it will not cover services rendered.*