



## MIDATLANTIC UROLOGY ASSOCIATES, LLC.

### OPT OUT WAIVER

I, \_\_\_\_\_ acknowledge that my Insurance Company, \_\_\_\_\_, requires that I have a Referral from my Primary Care Physician to use my HMO Level of Benefits.

By signing this form, I understand that I am choosing to be seen today by Dr. \_\_\_\_\_ without a Referral and **I will be financially responsible** for any balance after my insurance processes this claim.

Patient Name Printed: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Witness: \_\_\_\_\_