METROPOLITAN NEUROSURGERY, P.A.
INSURANCE WAIVER FORM

Patient's Name_____ **Date of Birth**_____

Welcome to our practice. We want to make sure that your visit goes smoothly and meets your expectations in every way.

Please take a moment to review the situations described below and place a checkmark by the paragraph that best describes your understanding of the requirements of your insurance plan:

☐ My insurance company does not require a referral for this visit. **I understand that I will be responsible for all charges that are not covered by my insurance company.**

☐ My Primary Care Provider has referred me for this visit and has obtained the appropriate referral from my insurance company. If a referral authorization number is not confirmed prior to consultation/treatment or by the time billing is made, **I understand that I will be responsible for all charges resulting from this visit.**

Patient Signature **Printed Name** **Date**

Parent or Guardian Signature Date