Meridian Surgical Services, Inc., P.S.
Robert C. Wright, M.D., F.A.C.S. & C. Anthony Kim, M.D., F.A.C.S.
1703 S. Meridian, Suite 304
Puyallup, WA 98371

WAIVER FOR FINANCIAL RESPONSIBILITY

_____ _____
Patient Name (Please Print) Date

Your physician may determine that your medical care requires you to obtain services from a provider other than your Primary Care Physician. When your physician refers you to another provider, except in cases of emergency, the referral must be approved by your insurance company and received in this office (as noted in your insurance contract), prior to obtaining those referral services. If you receive those services before making sure they are authorized, you will be financially responsible for the service.

Please read and sign the following statement:

"I have been informed by my physician that if I receive referral services before they are authorized, I will be personally responsible for payment"

_____ _____
Signature Date

Insurance company requiring referral: _____

Name of Referring Physician: _____