

SOUTH COAST DERMATOLOGY

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REFERRAL WAIVER

By signing below I acknowledge that there is no valid referral for my visit today as required by my insurance. I understand that I may be seen today and that it is my responsibility to obtain the referral from my primary care doctor. If a referral is not received by our office within the next **48 hours**, I will be solely responsible for the full amount of the services rendered to me today. Please have your Primary Care Physician's office fax your referral to **781-335-9709** or call our referral voice mail at **781-413-2531** with your referral information.

PATIENT NAME: _____ DOB: _____

SIGNATURE: _____

DATE: _____

90 LIBBEY INDUSTRIAL PARKWAY SUITE 200 WEYMOUTH, MA 02189
TEL: 781-335-9700 FAX: 781-335-9709

PATIENT COPY

I have signed a referral waiver at the office of **South Coast Dermatology** on _____ . I am responsible for calling my primary care physician's office to request my referral. It is my responsibility to make sure my primary care physician's office either calls or faxes my completed referral to the office of South Coast Dermatology. If this information is not received within 48 hours I will be solely responsible for the full amount of the visit as my insurance company will not pay without a valid referral.

Referral voice mail number: **781-413-2531**.

Fax number: **781-335-9709**

Billing Department: **781-413-2525**

Thank you.