



The Virginia Center for Allergy & Asthma

Robert A. Sikora, M.D., FAAAAI

WAIVER FOR NO REFERRAL

I understand that if I am required to have a referral or authorization for any services rendered at this office and I do not have one, I will be responsible to pay the allowed amount for the services rendered as contractually agreed upon between Dr. Sikora (Virginia Center for Allergy & Asthma) and my insurance company. This waiver begins today and does not expire.

Patient Name: _____

Patient Account Number: _____

Responsible Party Name: _____

Responsible Party Signature: _____

Date: _____