The Virginia Center for Allergy & Asthma

Robert A. Sikora, M.D., FACAAI
Darshana Alle, M.D.

WAIVER FOR NO REFERRAL

I understand that if I am required to have a referral or authorization for any services rendered at the office of The Virginia Center for Allergy and Asthma, and I DO NOT have a referral, I will be responsible to pay the allowed amount for the services rendered as contractually agreed upon by the physicians of The Virginia Center for Allergy and Asthma and my insurance company. This waiver begins today and does not expire.

_____

Printed Name of Patient

_____

Signature of Patient/Parent/Representative/Guardian

_____

Printed Name of Parent/Representative/Guardian (if applicable)

_____

Date

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703.670.3900

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Fredericksburg, VA 22401
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