ESSEX HEMATOLOGY-ONCOLOGY GROUP, P.A.
36 Newark Ave, Suite 304
Belleville, NJ 07109
(973) 751-8880

DATE:_____

PATIENT:_____

I understand that my insurance requires that I have a referral from my primary care physician when being seen by a doctor of Essex Hematology-Oncology Group, P.A.. At this time, I do not have a referral with me for this visit. In the event that I or the staff of Essex Hematology-Oncology Group, P.A., cannot obtain a referral from my primary physician for this visit/treatment within 1 business day, I understand that I am financially responsible for this visit.

Please circle one of the following options below:

1. In the event the referral is not obtained for the appropriate date of service, I understand that my credit card will be charged for the visit/treatment for the above date of service.
Type of Credit Card: ___Amex ___ Disc ____ MC ____ Visa

Credit Card #:_____ Expiration date: _____

2. In the event the referral is not obtained for the appropriate date of service, I understand that my check will be cashed for the visit/treatment for the above date of service.

3. In the event the referral is not obtained for the appropriate date of service, I understand that my cash deposit will be deposited for the visit/treatment for the above date of service.

_____

Patient Signature Date Office Staff _____