

## **PATIENT RESPONSIBILITY DISCLAIMER**

NON –REFERRED VISITS TO A SPECIALTY PROVIDER ARE YOUR RESPONSIBILITY

I, \_\_\_\_\_ **UNDERSTAND** THAT IN ORDER TO  
PATIENT'S NAME  
COVER SERVICES PROVIDED; MY INSURANCE MAY REQUIRE A  
REFERRAL FROM MY PRIMARY CARE PROVIDER. I ALSO  
UNDERSTAND THAT IF MERIDIAN PARK RADIATION ONCOLOGY  
CENTER HAS NOT RECEIVED AUTHORIZATION FOR A REFERRAL  
FROM MY PRIMARY CARE PROVIDER OR IF MY INSURANCE DOES  
NOT PAY FOR MY MEDICAL SERVICES, I WILL BE FINANCIALLY  
RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED.

\_\_\_\_\_  
PATIENT'S SIGNATURE (RESPONSIBLE PARTY)

\_\_\_\_\_  
DATE

## **Designation of Authorized Representative**

I, \_\_\_\_\_, hereby grant Meridian Park Radiation  
PATIENT'S NAME  
Oncology Center (MPROC) the authority to act as my authorized  
representative in all matters related to treatments and services I  
received at their facility. This designation includes the authority to  
investigate and appeal any and all issues pertaining to medical and  
financial matters concerning service provided by MPROC and its  
associated physicians and providers.

\_\_\_\_\_  
PATIENT'S SIGNATURE (RESPONSIBLE PARTY)

\_\_\_\_\_  
DATE