



PREMIER *medical group*
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PATIENT TREATMENT WAIVER

I, _____ realize that I do not have the proper referral from my Primary Care Physician to cover the services that I am requesting from Premier Medical Group. Therefore, I will be responsible for the payment of this visit and all associated charges for me or my dependent(s).

Signed: _____

Date: _____

Witnessed: _____

Premier Medical Group of the Hudson Valley, P.C.

Urology · Gastroenterology · Internal Medicine · Cardiology · Rheumatology · Dermatology · Pediatrics · Podiatry · Neurology

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