

EASTERN VIRGINIA MEDICAL SCHOOL
DIVISION OF MATERNAL-FETAL MEDICINE
DIVISION OF GENERAL OBSTETRICS & GYNECOLOGY
DIVISION OF UROGYNECOLOGY

REFERRAL LETTER OF UNDERSTANDING

I, _____, hereby note that I am being seen at EVMS, Division of Maternal-Fetal Medicine, without the benefit of a valid referral form or authorization, as required under my Health Plan's referral Policies. I understand that I may be responsible for full or partial payment of any charges resulting from this visit and/or diagnostic testing that may occur. I understand that retroactive referrals are generally not allowed by my plan, and that any referrals produced after this form is signed may not be considered valid.

Understanding all of the above, I hereby accept that risk and still want to complete this visit.

Insured (or parent/guardian)

Date

EVMS HS Staff

Date