



## Referral Policy

I understand that the policies and rules of health plans vary greatly and that Dr. Gordon and his staff have made every effort to be fair in determining whether I need a referral for my office visit.

I also understand that Dr. Gordon and his staff cannot expend the time required to phone my plan and wait on hold to find out what is my health plan's policy regarding referrals.

I understand that because I am ultimately responsible to know the features of my plan, that I will be financially responsible should my plan deny any payment to Dr. Gordon for my ocular evaluation.

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**Patient Signature**

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**Date**